Health Care Financing

A Decade of Medicaid Experience, Fiscal Years 1973 Through 1982

Health Care Financing

Grants and Contracts Report

The Office of Research and Demonstrations, Health Care Financing Administration, directs more than 300 intramural and extramural research, demonstration, and evaluation projects. These projects seek alternate ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. The Health Care Financing *Grants and Contracts Report* series represents the final reports from selected extramural projects funded by the Office of Research and Demonstrations. The statements and data contained in each report are solely those of the contractor or grantee and do not express any official opinion of or endorsment by the Health Care Financing Administration.

A Decade of Medicaid Experience, Fiscal Years 1973 Through 1982 analyzes Medicaid expenditure trends and the differences in growth for particular services, by eligibility class by State for the period 1973 through 1982. A second goal is to relate contextual influences (such as the general inflation in medical care prices) and changes in program characteristics to the recent and longer-run expenditure trends. The possible links between the dramatic slowdown of Medicaid expenditure growth in 1982 and specific program changes by Federal and State governments receives special attention.

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A Decade of Medicaid Experience, Fiscal Years 1973 Through 1982

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
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EXECUTIVE SUMMARY

A. Purpose

The primary goal of this report is to assist public officials and researchers to become better informed about Medicaid expenditure trends and the differences in growth for particular services, by eligibility class, by state and for sub-periods of the decade. A second goal is to relate contextual influences (such as the general inflation in medical care prices) and changes in program characteristics to the recent and longer-run expenditure trends. A fairly dramatic slowdown of Medicaid expenditure growth in Fiscal Year 1982 was observed in many of the states. The possible links between this development and specific program changes by federal and state governments will receive special attention.

B. Highlights

(1.) During the decade 1973-82, Medicaid vendor payments, in total and per recipient, grew at remarkably rapid rates until FY82 when, for the first time in program history, vendor payments grew more slowly than the medical component of the Consumer Price Index. The long term growth rate of total payments was steadily above 15% per year, falling to about 10% in FY82. Payments per recipient, deflated by the medical care price index, grew by 4% per year from 1973 to 1979, by 3.1% per year from 1979 to 1981, and declined slightly in 1982.

(2.) The number of Medicaid recipients has fluctuated between 20 million and 25 million during the decade; the percentage of recipients in the U.S. population ended the decade at 9%, only slightly higher than in 1973. A sharp growth in the number of recipients coincided with the recession of 1974-75. However, a similar increase did not occur during the severe recession in 1982.

(3.) Comparing across the states, variation in Medicaid payment growth rates is substantial. While the average annual growth rate of payments for the nation was 14.8%, 13 states had rates exceeding 20%. The distribution was not symmetric -- no state had a growth rate below 10% and only two states had growth rates below 12%. The proportion of state general expenditures represented by Medicaid payments in 1982 was 5.4% on average, with New York at the high rate of 11% and Alaska and Wyoming both with less than 1%.

(4.) The OBRA and TEFRA legislation (1981 and 1982, respectively) have permitted and encouraged state policies to reduce Medicaid

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expenses. Lower federal matching rates had more than an equal proportional effect on state expenses.[1] Both passive policies (e.g., not increasing over time the income cutoff for eligibility) and active policies (e.g., placing limits on covered hospital or nursing home days) are evidenced in the last two years. Departures from the former Medicare rules for inpatient hospital payments or restriction of AFDC eligibility do not appear to have major importance for the differences among states in the 1982 slowdown. On the other hand, it appears that restrictive changes in definitions of income and covered expense for SSI and medically needy groups, as well as utilization and price limits for hospitals and nursing facilities may have been important.

(5.) Over the entire decade, one of the major reasons for rapid growth in Medicaid payments was the rising use of new or previously little-utilized services. For example, since 1979, intermediate care facilities for the mentally retarded have accounted for 20 to 25 percent of total Medicaid payment growth each year.

Another major long-term contributor to (deflated) Medicaid payment growth is the shift in recipient mix toward more expensive patients. This shift to more expensive patients is reflected by the growth of the more costly disability population, including the institutionalized mentally retarded, as a share of all Medicaid recipients and the shift from aged cash assistance recipients to the more costly medically needy and institutionalized recipients.

(6.) The slowdown in Medicaid payment growth in 1981-82 occurred for almost all service categories and for all four major eligibility categories, with an absolute decline in payments for AFDC children. Also, this slowdown was not limited to just a few states. The number of states with a growth rate above 15% dropped by two-thirds (to 10 states), while the number with a growth rate of less than 5% tripled (to 16 states).

Contrary to the long term trends, there was a reduction in 1982 in recipients using hospital inpatient and nursing facility services. Thus, while the total number of recipients declined .8 percent from 1981 to 1982, the number of recipients using hospitals declined 3.7 percent and the number of recipients using nursing homes (not for the mentally retarded) declined 3.4 percent. (There has been only a small positive

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[1]This is illustrated as follows. If the federal matching rate fails from 55% to 52%, then even if total payments are unchanged, state payments would rise by 6.7%. The sharpest changes occur for the states with the highest existing federal matching rates.

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correlation across states of the growth in expenses in these two service categories.) This finding and the other special attributes of the 1981-82 slowdown cannot at this time be confidently projected into the future as demographic trends, the economic environment and state policies continue to evolve.

1.0 INTRODUCTION

This document provides descriptive details and selective analyses of national trends in expenditures and recipients for the Medicaid program (Title XIX of the Social Security Act). The report includes fiscal years 1973 through 1982, thereby encompassing and extending the national trends described in two earlier HCFA publications, namely, the National Annual Medicaid Statistics: Fiscal Years 1973 Through 1979[2] (to be cited as the Muse Report), and The Medicare and Medicaid Data Book, 1981[3] (to be cited as the 1981 Databook). This report expands on those works by providing detailed state-by-state comparisons of program experience over time.

1.1 Program Summary

Medicaid is the federal-state vendor payments program designed to pay for health care services used by eligible people. It is operated and partially funded by the states under general federal rules and with federal financial assistance. The basic federal Medicaid law is Title XIX of the Social Security Act, passed in 1965, and its amendments. Although changes have been made over the years, the essential structure of the program has remained unchanged since its creation. States have considerable flexibility in the design of their Medicaid programs. Detailed variation from state to state in major policies will be presented in Section 4 of this report.

Certain features are critical to understanding the program: First, Medicaid eligibility is temporary and depends on an individual's income, resources, and family composition. People who are eligible to receive cash grants under the federally assisted Aid to Families with Dependent Children program (AFDC) are automatically eligible and, in most states, so are all recipients of Supplemental Security Income (SSI) grants. In addition, some states have chosen to include individuals who would be

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[2]HCFA Publication No. 03133, August 1982.

[3]HCFA Publication No. 03128, April 1982.

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entitled to those grants except that their incomes are somewhat higher (up to 133 1/3% of the maximum payment to comparable AFDC families) than grant recipients.

Secondly, Medicaid eligibles in all states are entitled to certain federally mandated services (inpatient and outpatient hospital services, physician services, skilled nursing facility services, laboratory and x-ray services, early and periodic screening, diagnosis, and treatment services for children, and family planning) and, in addition, states cover a variety of optional services, such as dental care and home health services.

And, thirdly, for the most part, providers of institutional care are reimbursed on the basis of their costs, while physicians and other professionals are paid on the basis of charge profiles and/or fee schedules. Hospitals and skilled nursing facilities have generally been paid according to the cost-based principles adopted by the Medicare program. Other nursing homes, however, have often been subject to per diem limits. With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981, states can now be exempted from Medicare cost reimbursement rules after receiving special approval from the Secretary of the Department of Health and Human Services for an alternate plan. A new prospective payment system for hospitals was adopted for Medicare in 1983; it does not automatically apply to Medicaid, although individual states may experiment with such arrangements.[4]

These provisions regarding eligibility, benefits, and payment of providers create a measure of uniformity across the states. However, since the states operate the program, pay part of the bill, and make many decisions about the structure and substance of the program, it is not surprising that Medicaid varies considerably from state to state. Important differences can be observed regarding:

- o eligibility criteria -- all AFDC recipients are eligible, but the states determine who receives AFDC; some states cover the medically needy, but others do not;

- o benefits -- all states must cover the mandatory services, but they can decide whether to limit the amount of each that is

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[4]New Jersey has applied such a system to Medicaid for several years, Pennsylvania is initiating a new system and other states are planning such efforts.

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covered, whether to apply special conditions to the use of some services, and whether and to what extent to cover other services;

- o payments -- physicians are not necessarily paid on the basis of costs; states may set fees, for example, on the basis of fixed schedules or a percentage of Medicare allowable fees. Nursing facilities are paid under a variety of prospective and retrospective rate-setting methods.

- o administration -- all states must arrange for the payment of bills, for example, but some do it themselves while others contract with private firms to process claims; some analyze data from those claims for management and planning purposes, but others do not.

Recent changes in federal law have retained this same basic structure in which states operate Medicaid programs and are reimbursed by the federal government for a portion of their expenditures. The federal share is inversely related to state per capita income so that a relatively poor state would be reimbursed a higher percentage of its expenditures than a wealthier state. In 1980, the federal matching rate ranged from 50% (e.g., California, Delaware) to 78% (Mississippi). The Omnibus Budget Reconiciliation Act (OBRA) of 1981 reduced the federal financial contribution below the percentage in effect in FY 1981 by 3% in FY 1982, 4% in FY 1983, and 4.5% in FY 1984. The cut can be reduced by one percent if the state operates an approved hospital rate-setting program, has an unemployment rate above 150% of the average nationwide, or has a recovery program for fraud, abuse and third-party liabilities which collects more than 1% of the federal contribution. The intent was to reduce federal outlays while at the same time increasing the states' interest in running cost-conscious programs.

The 1981 Act changed some eligibility provisions too, in order to remove certain groups from the rolls and to give states more choices about coverage. Among the changes were the following: states were given the option (previously, it was mandatory) to include those who would be eligible for AFDC payments if they were in school; states with a medically needy component could vary eligibility criteria between categorical groups (e.g., aged vs. disabled); states were given new rules which limited the extent to which certain expenses could be used to reduce an individual's income, thereby reducing AFDC eligibles; and states were permitted to provide AFDC grants (and therefore Medicaid coverage) for first-time pregnant women only from the 6th month of pregnancy onward (although they could continue to provide Medicaid coverage at the point the pregnancy was established). These and other

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eligibility provisions were expected to reduce Medicaid expenditures somewhat.

Section 2176 of the OBRA of 1981 also permitted states to request that the Secretary of the Department of Health and Human Services waive the state-wideness and comparability requirements[5] of the program in order to permit states to encourage the development of home and community-based services for recipients who would otherwise require services in long-term care facilities. (Coverage of such services already required special approval from DHHS.) Section 2175 permitted other innovations, including competitive bidding for the purchase of laboratory and other services; lock-in to a particular provider for recipients who overuse services; exclusion of providers who abuse the program (lock-out); case management or preferred provider arrangements; and a broker function to help eligibles select among competing alternative plans.

Similarly, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) also contained provisions affecting Medicaid, but it, too, left the structure of the program intact. For example, it permitted states to impose nominal copayments on certain services and/or certain client groups in order to deter unnecessary utilization. It also permitted states the option to add certain medically needy groups (such as pregnant women and children) without having a full medically needy program component.

States have been making changes in their program characteristics for as long as they have had programs. In later sections of this report, data will be presented on the extent to which programmatic decisions differ among the states, the degree to which the states have taken the opportunity to make the changes contemplated in recent legislation, and the possible impacts of policy on expenditure trends.

1.2 Sources and Limitations of Data

The information presented in this report on Medicaid recipients and payments was compiled primarily from annual reports from state Medicaid agencies using HCFA Form 2082. A minority of states, particularly in the early years of the decade, were not able to supply the detailed information breakdowns requested. County governments in some states

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[5]Title XIX requires that the program be the same in all parts of the state and that all categorical eligibles be entitled to the same services.

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were not using standardized information systems capable of providing complete reports to their state agencies. New York is the notable state for which the requested detail in Form 2082 could not be constructed directly before 1982. In such cases, HCFA has undertaken to interpolate payment and recipient data for missing categories of eligibility and service type. A more thorough discussion of the strengths and weaknesses of this data base and other Medicaid data sources is available in Heinberg and Adler (1982).

Compilations of data on state Medicaid program characteristics were produced by LaJolla Management Inc., and Systemetrics Inc. under contract to HCFA. Other measures were obtained from the National Governors Association and from secondary published sources to be indicated where applicable.

2.0 PAYMENTS AND RECIPIENTS AT THE NATIONAL AGGREGATE LEVEL

2.1 Introduction

The overall growth in Medicaid payments over the past decade appears to reflect both the national experience with all medical care costs and a large increase in payments for some of the newer service categories over the period. The rate of growth in payments from 1981 to 1982, however, did not follow the previous trend. Instead, it was far lower than would have been predicted from previous Medicaid growth or growth in overall United States health expenditures for this year.

This section proceeds as follows. First, overall national trends in Medicaid payments and recipients are detailed. These trends are compared to national trends in health expenditures, state budgets and personal income. Then the individual service and eligibility components of Medicaid payment growth are examined to highlight areas of high growth and/or national concern given expected demographic trends in the next decade.

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2.2 Overall National Trends

Table 1 provides fiscal year Medicaid vendor payments, numbers of recipients and expense per recipient. These data include Puerto Rico and the Virgin Islands, which, due to the special nature of their medical care programs, are excluded in all subsequent tables unless specifically noted.[6] Vendor payments in this table include all payments to physicians, hospitals and other health care providers during the fiscal year. Additional expenses of the Medicaid program include payment of the Medicare Part B premium for some older and disabled persons, and general state administration costs. Some payments in one year are for services rendered in an earlier year. From other HCFA data sources, it appears that the backlog of such payments does fluctuate from year to year and mandates caution in interpreting any particular year.[7] It is clear from Table 1 that the 246% increase in payments over the decade has very little to do with the growth in the total number of recipients.

Table 2 describes annual Medicaid growth rates in the past decade, disaggregated into three time periods. The average annual (compound) growth rate in total payments was 15.6 percent between 1973 and 1979, the period covered by the Muse Report; it remained at approximately this same level between 1979 and 1981 and then dropped sharply from 1981 to 1982, to 9.8 percent.[8] This subdivision of the decade was determined by a preliminary study of the individual years, as graphed in Figure 1, indicating that the slowdown did not begin until FY82.

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[6] A discussion of the Medicaid program in Puerto Rico is provided by Pagan-Berlucchi and Muse, "The Medicaid Program in Puerto Rico: Description, Context, and Trends," Health Care Financing Review 4, Summer 1983.

[7] Based on a comparison of HCFA Form 64 fiscal data for the first quarters of 1981, 1982 and 1983, it does not appear that "payment lag" is an explanation of the 1982 slowdown.

[8] One other period, 1977-78, also had a similarly low 10.4% Medicaid growth rate. However, that was a period of economic expansion as compared to the worsening economic situation between 1981 and 1982.

Table 1

AGGREGATE MEDICAID EXPERIENCE, FISCAL YEARS

Year	Vendor Payments ($ million)	Recipients (000)	Expense per Recipient
1973	8,640	19,622	$440
1974	9,983	21,116	473
1975	12,292	22,223	553
1976	14,135	22,891	617
1977	16,277	22,920	710
1978	17,966	22,198	809
1979	20,474	21,540	950
1980	23,301	21,604	1,079
1981	27,212	21,980	1,238
1982	29,906	21,936	1,363
Growth, 1973-82	246%	12%	210%
Annual Compound Rate	14.8%	1.2%	13.4%

Source: 1975-82 from HCFA data tape of forms #2082; 1973 and 1974 from DHEW No. 76-03153 and 77-03153. Includes Puerto Rico and Virgin Islands.

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Table 2
MEDICAID GROWTH RATES WITHIN THE DECADE 1973-82
(Fiscal years; Puerto Rico and Virgin Islands excluded)

	Average Annual Growth Rate (%)		
	1973-79	1979-81	1981-82
Total Recipients	1.6	1.1	-0.8
Recipients per Capita	.5	1.8	-1.8
Total Payments	15.6	15.4	9.8
Total Payments, deflated*	5.6	4.2	-1.0
Payments per Recipient	14.0	12.6	11.2
Payments per Recipient deflated*	4.0	3.1	-0.2

*The deflator is the medical care component of the Consumer Price Index, produced by the Bureau of Labor Statistics. Population data are from various issues of the Statistical Abstract of the U.S., and other program data sources are the same as for Table 1.

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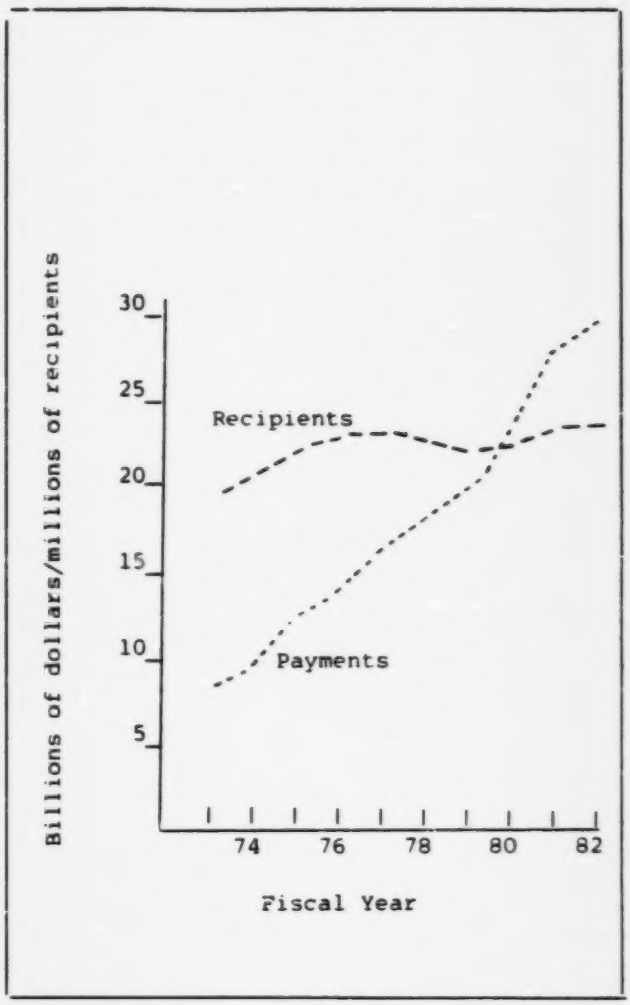
Figure 1
Trends in total payments and recipients



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In order to interpret properly any time series of expenditures, it is important to separate trends in price levels from trends in the quantity of "real" consumption or production. This is not so easy in the case of Medicaid expenditures because state agencies may not be paying the market prices used in computing price indexes for medical care. Nevertheless, it is useful to deflate Medicaid expenses by a market price index in order to control for supply conditions within the health sector and general economy-wide inflation. Table 2 shows that the deflated rate of growth also dropped sharply this last year in the series, with deflated Medicaid payments declining 1.0 percent, which is unprecedented in the history of the program.

Figure 2 displays the logarithm of deflated Medicaid payments and the percent of U.S. residents who were Medicaid recipients between 1973 and 1982. (A display of the logarithm of a series is convenient since a trend with a constant rate of growth will appear as a straight line.) We note first that the decline in the number of recipients in 1982 was responsible for some of the drop in total Medicaid payments, a finding all the more surprising since 1982 was a year of major recession. For example, the last major recession corresponds to the 1974-1976 rise in total recipients. Such an effect is not evident in the current recession, dated from mid-1981 to the end of 1982.

The drop in recipients in 1982, while surprising, was only one major factor accounting for a negative deflated growth rate. Declines in recipients during the late 1970's were associated with positive growth in real expense. Table 2 illustrates both actual and deflated growth in Medicaid payments and payments per recipient. Deflated (real dollar) growth represents the growth in medical payments after removing the increase in payments due to the increase in medical care prices, as measured by the medical care component of the Consumer Price Index. As seen in Table 2, deflated payments per recipient also dropped dramatically in this last year. Apparently, Medicaid policy changes had a dramatic effect on both numbers of recipients and payments per recipient in fiscal year 1982. The latter may reflect changes in payments per recipient of a given type and/or may reflect changes in patient mix.

The growth of payments for medical care at all levels of government has outstripped many other categories of spending, leading

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to increased scrutiny of policy options. However, the magnitude of state Medicaid payments in relation to overall health spending and fiscal burdens should not be exaggerated. Table 3 shows how Medicaid payments in the last decade compared to total personal medical expenditures and total personal income. It also shows state Medicaid expenditures as a proportion of total state general operating expenditures and reports the ratio of Medicaid recipients to an estimate of the population with incomes below the poverty level.

Medicaid's proportion of the total medical care bill remained relatively constant over the period, rising from 11 percent in 1973 to 12 percent in 1981, and back down to 11 percent in 1982. As a proportion of state spending, state Medicaid payments did grow over the period, from 3.9 percent of state general operating expenses in 1973 to 5.8 percent in 1982, but this is not an increase that, by itself, would require drastic actions for state solvency. For example, during this period some reallocation of budgets from primary and secondary education to other programs, such as Medicaid, might have been expected as a result of demographic trends. Substantial growth of budget share also occurred for cash welfare payments, higher education, prisons, and general administration (U.S. Bureau of the Census, Governmental Finances, annual issues). Aggregate state Medicaid expense was about $15.5 billion in 1982 (Gibson and Waldo, 1983) which is less than half of the total state expenditures on personal health care ($32 billion) including some services and populations not eligible for federal matching funds. Clearly, if state financial problems are a major underlying cause of Medicaid cutbacks in 1982, these budgetary problems go beyond the Medicaid payment spiral.

The percentage of United States personal income that is spent on the Medicaid program has also increased over this period, from .9 percent in 1973 to 1.2 percent in 1982. This growth is part of the overall increase in the U.S. GNP going for medical expenditures (from 7.8% in 1973 to 10.5% in 1982). However, despite the increase in the Medicaid burden, the ratio of Medicaid recipients to the population with incomes below poverty level has been declining sharply in recent years.[9] This ratio increased from .87 in 1973 to .98 in 1976, but has since dropped, to .61 in 1982. Since not all Medicaid recipients

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[9]The conventional definition of poverty underlying these calculations ignores transfer payments such as food stamps and housing subsidies, and therefore tends to overstate the extent of poverty in any given year.

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Figure 2
Recipients per capita
and deflated payments

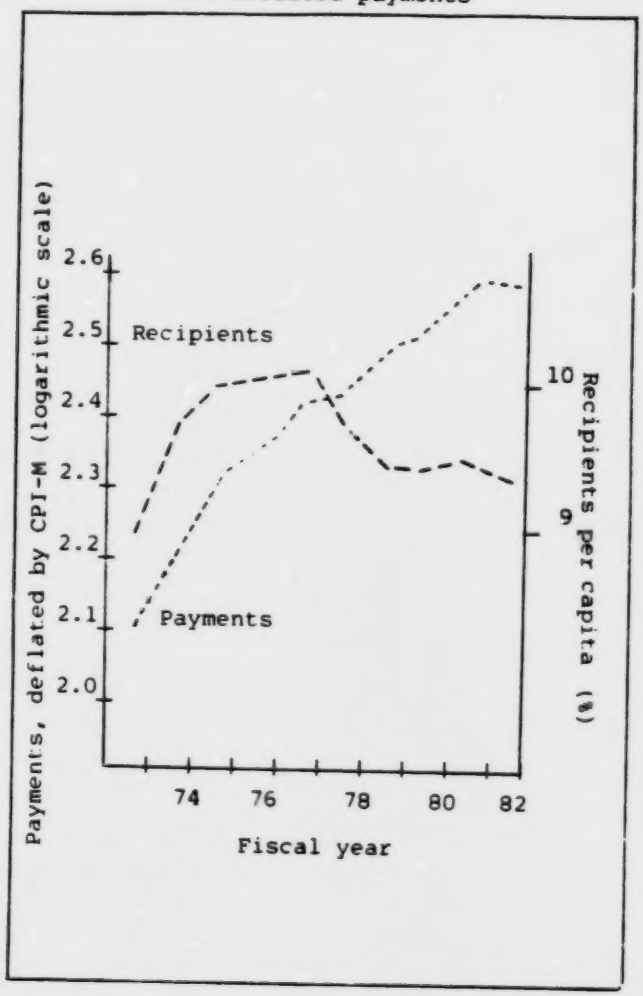

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Table 3
MEDICAID PAYMENTS AND RECIPIENTS
EXPRESSED AS A PROPORTION OF OTHER NATIONAL AGGREGATE MEASURES

	Medicaid Payments Divided by Total Personal Health Care Expenditures	Medicaid Payment Divided by Total Personal Income	State Medicaid Payments Divided by State General Operating Expense	Recipients Divided by Poverty Population
1973	.11	.009	.039	.87
1974	.11	.010	.041	.94
1975	.12	.011	.045	.87
1976	.12	.011	044	.98
1977	.12	.012	.046	.96
1978	.12	.011	.048	.94
1979	.12	.012	.049	.82
1980	.12	.012	.053	.74
1981	.12	.013	.054	.69
1982	.11		.058	.61

SOURCES: Total personal health care expenditures are from Waldo and Gibson (1982); Total personal income is from U.S. Department of Commerce, as reported in the Statistical Abstract of the United States 1982-83, and earlier years; Total state general operating expenses are from the Census Bureau GF82 No. 3 and analogous tables for other years reprinted in the Statistical Abstract. Expenses for employee insurance and pension programs and for retail state enterprises are excluded. State Medicaid Payments (excludes "state-only" medical assistance and other health care programs) are from Waldo and Gibson (1982) and are for the calandar year while state general operating expenses are for the fiscal year. Counts of the population in families below the poverty level of income are from the Census Bureau, Current Population Reports, Series P-60, No. 140 and earlier reports.

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are individuals below the poverty line and since the number of Medicaid eligibles exceeds the number of Medicaid recipients, the simple ratio can be misleading. Nevertheless, the downward trend in this ratio does suggest that fewer of the poor and medically needy are now receiving medical care through the Medicaid program than was true earlier in the decade.

None of these figures is intended to deny the problems which Medicaid growth created for the states. The increased share of state operating expenses attributed to Medicaid may be only 1.9%, but that represents many additional millions of dollars that state governments had to raise in 1982 over 1973 needs. Nonetheless, they do serve to point out that Medicaid's growth was part of a general growth in spending on health care, in personal income, and in state government as a whole. Moreover, in the process, the share of the poverty population (using the narrow cash income definition of poverty) receiving Medicaid benefits declined substantially.

2.3 Payments and Recipients by Service Category

The increase in overall Medicaid payment levels is comprised of payments for both acute and long term care; some service sectors have shown remarkable growth while for others growth has been more moderate. Table 4 details payment levels for 1973 and 1982 and then disaggregates the growth in payments during this period into three periods: 1973 to 1979, the period covered in the Muse report, 1979 to 1981 and 1981 to 1982.

The largest single service category, inpatient hospital services, is seen to follow the overall pattern for Medicaid payments, although the growth rate is less than the average for all services combined. These observations contrast with the relatively higher growth of inpatient expense for the non-Medicaid population. Despite expectations of considerable growth as the average age of the population, long term care not associated with the mentally retarded has not increased at a notably faster rate than total Medicaid payments since 1979. Subsequent to the fast rise in payments to intermediate care facilities (ICFs) from 1973 to 1979, the rate of growth in payments has appeared to stabilize.

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The most dramatic increase is seen for ICF services for the mentally retarded. Expenditures for ICF-MR were at $165 million in 1973, less than two percent of the Medicaid budget, but by 1982 they accounted for more than twelve percent of the Medicaid budget (Table 5). The growth rate in payments of 22.1 percent for ICF-MR in 1981-82, while still remarkably large, was a substantial drop from prior growth rates in excess of 40 percent. This growth in ICF-MR payments accounted for almost one quarter of the increase in overall Medicaid payments between 1981 and 1982, slightly greater than the increase in Medicaid payments accounted for by inpatient hospital services.

At present, about 1800 ICF facilities across the country are certified for Medicaid coverage of mentally retarded residents.[10] Most of the growth in certified beds has resulted from the upgrading of preexisting state-operated facilities. Over a billion dollars have been invested by states in this process, and in 1982 only Wyoming had no certified beds.

The share of payments going to physicians has continued to decline over the period, from 10.6 percent of total payments in 1973 to 7.1 percent of payments in 1982 (Table 5). Medicaid payments for hospital outpatient services, at 5.1 percent of total payments in 1982, may soon exceed payments to physicians if current trends continue.[11] Also note that payments to dentists and to other

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[10]Information provided by Charles Laken of the Center for Residential and Community Services, University of Minnesota.

[11]Unfortunately, it is not possible to determine how much of this "substitution" of expenses represents a shift in utilization, and how much is a faster of rise of unit prices paid to hospitals compared to rates paid to office-based physicians. That question has been examined, for Medicare only, by Manheim and Friedman (1982) who attributed a somewhat larger share of the growth to relative price increases than to utilization shifts during the 1970s.

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Table 4
PAYMENT LEVELS AND GROWTH BY SELECTED SERVICE TYPES, 1973-1982

Service Type	Payments ($million) 1973	1982	Annual Growth Rate (%) 1973-79	1979-81	1981-82
TOTAL	8,543	29,787	15.6	15.3	9.9
Inpatient Hospital	2,629	7,789	13.5	12.9	8.8
ICF, non-mentally retarded	895	4,978	27.2	9.3	10.2
SNF	1,959	4,383	9.5	8.9	9.8
ICF/Mentally Retarded	165	3,609	44.5	40.7	22.1
Physicians' Services	902	2,107	10.2	13.9	.4
Prescribed Drugs	591	1,599	12.2	13.9	4.5
Outpatient Hospital	267	1,513	20.9	26.7	13.1
Mental Health, Inpatient	349	1,031	14.4	9.8	9.7
Dental Services	205	504	13.2	12.3	-7.1
Home Health Services	25.3	496	47.9	27.6	15.6
Clinic Services	237	411	2.6	16.4	10.1
Other Practitioners	81.9	226	12.2	18.2	-.9
Family Planning	NA	134	NA	11.9	-1.5
Lab and X-ray	101	161	10.3	-10.0	9.5
Early and Periodic Screening	NA	72	NA	NA	11.7
Rural Clinic Services	NA	3.6	NA	NA	-11.6
Other Care	137	771	13.3	50.6	17.8

Sources: 1973 from NCSS document B-4; 1979, 1981 and 1982 from unpublished HCFA data Forms 2082. Puerto Rico and Virgin Islands are excluded.

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practitioners declined between 1981 and 1982, perhaps due to a limiting of coverage or of payment for such services by the states.

Table 6 shows the levels of and growth in recipients over this same period. The notable decreases in numbers of recipients for almost all service categories in the last year for which data are available is the most remarkable feature of this table. Even the sharp, steady increases in the growth of hospital outpatient department recipients from 1973 to 1981 were reversed in this last year. It appears from Table 6 that the .8 percent overall decline in Medicaid recipients, while surprising in a recession year, understates the larger declines in utilization of many specific service categories, and that these declines in total services per recipient are important for understanding the deceleration of Medicaid payments growth between 1981 and 1982.

2.4 Payments and Recipients by Eligibility Category

The level of payments for 1973 and 1982, and the growth in payments between these two years by eligibility category, is presented in Table 7. Table 8 presents similar information on numbers of recipients by eligibility category. Table 7 shows that the dominant share of total Medicaid payments goes to the aged and disabled; each group accounted for more than $10 billion in 1982. The disabled category has had the most rapid growth in payments. While the aged and disabled account for over 70% of all payments, they represent only 29% of recipients.

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Table 5
SHARES OF SELECTED SERVICES
IN THE LEVELS AND GROWTH OF TOTAL PAYMENTS

Service	Share of Total Payments (%) 1973	1982	Share of Total Medicaid Growth (%) 1973-79	1979-81	1981-82
TOTAL	100	100	100	100	100
Hospital Inpatient	30.8	26.1	25.2	22.9	23.5
ICF-MR	1.9	12.1	11.2	21.7	24.4
ICF-all other	10.5	16.7	24.4	11.0	17.2
SNF	22.9	14.7	11.9	9.3	14.6
Physicians	10.6	7.1	6.0	7.1	.3
Hospital Outpatient	3.1	5.1	4.8	7.5	6.6
Drugs	6.9	5.4	5.0	5.2	2.6
SUBTOTAL	86.7	87.2	88.5	84.7	89.2
All Other Services	13.3	12.8	11.5	15.3	10.8

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Table 6
TOTAL RECIPIENTS AND GROWTH RATES BY SELECTED SERVICE TYPES, 1973-1982

Service Type	Recipients (000) 1973	1982	Annual Growth Rate (%) 1973-79	1979-81	1981-82
TOTAL*	18,295	20,944	1.6	1.1	-.8
Inpatient Hospital	3,163	3,528	2.6	-.3	-3.7
ICF, non-mentally retarded	440	766	9.6	.5	-.3
SNF	689	558	-2.3	.3	-7.4
ICF/Mentally Retarded	30.4	154	24.9	22.8	-11.2
Physicians' Services	12,088	14,017	2.0	2.9	-2.7
Prescribed Drugs	11,034	13,668	3.1	3.6	-4.1
Outpatient Hospital	5,279	8,501	6.0	7.0	-.8
Mental Health, Inpatient	81.0	76	-.5	11.3	-21.7
Dental Services	2,868	4,922	7.1	9.5	-4.9
Home Health Services	114	396	21.1	5.8	-1.5
Other Practitioners	1,949	3,267	7.7	8.7	-8.9
Clinic Services	1,981	1,738	-4.0	6.5	-.9
Family Planning	NA	1,476	NA	9.5	2.7
Lab and X-ray	3,702	3,962	5.3	-12.0	1.7
Early and Periodic Screening	NA	1,813	NA	NA	-.4
Rural Clinic Services	NA	60	NA	NA	-25.7
Other Care	2,333	2,386	-.7	.9	4.7

Sources: 1973 from NCSS document B-4, 1979 and 1981 from unpublished HCFA data Forms 2082. Puerto Rico and Virgin Islands are excluded.

*A recipient may be represented in more than one service category.

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Figure 3
Share of Total Medicaid Payments
By Service and Year

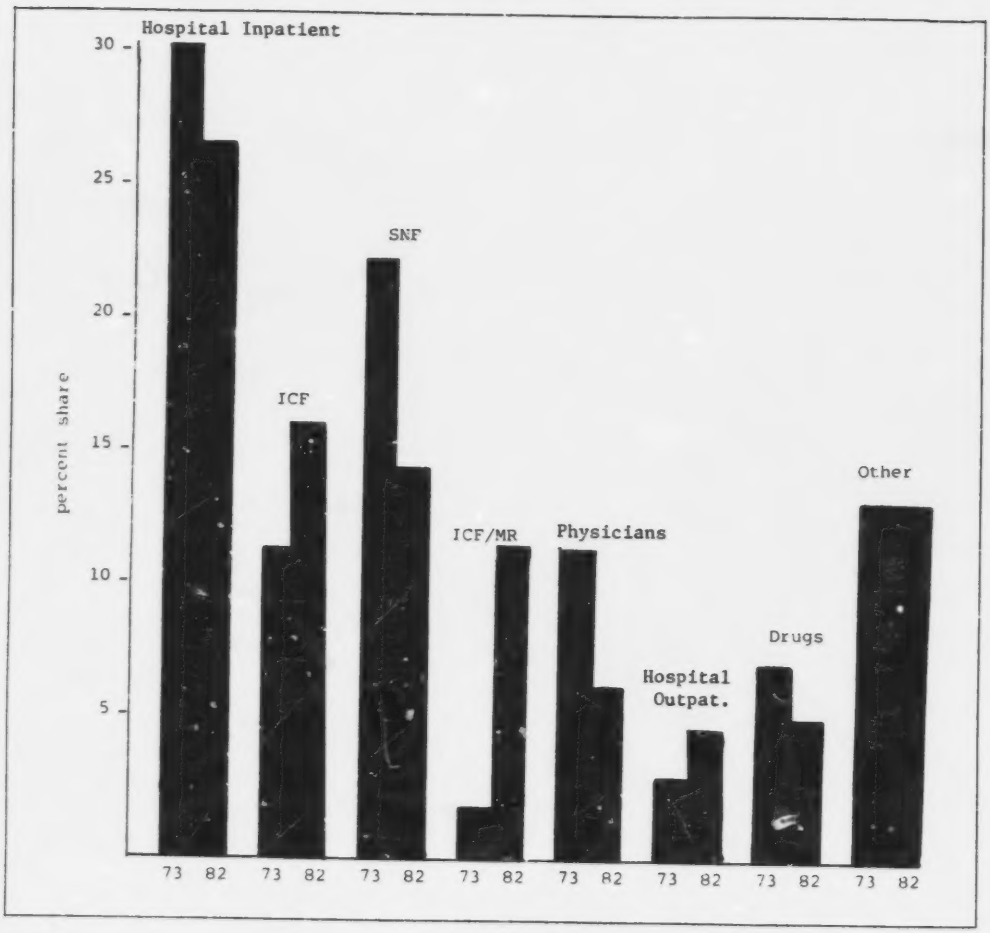

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Table 7
PAYMENTS BY ELIGIBILITY CATEGORY, 1973-1982

Eligibility Category	Payments ($million) 1973	1982	Annual Growth Rate (%) 1973-79	1979-81	1981-82
TOTAL	8,543	29,787	15.6	15.4	9.8
With cash grants	4,725	16,204	15.2	14.9	11.1
Without cash grants	3,818	13,583	16.1	15.9	8.2
Aged	3,229	10,854	13.9	17.9	10.8
Blind	65	174	9.0	13.3	24.2
Disabled	2,009	10,495	22.6	16.5	13.3
Children, AFDC	1,379	3,531	13.2	11.2	-1.4
Adults, AFDC	1,437	4,144	13.0	12.6	8.9
Other Title XIX	424	588	2.9	3.7	8.9

Sources: 1973 from NCSS document B-4; 1979, 1981, and 1982 from unpublished HCFA data Forms 2082. Puerto Rico and Virgin Islands are excluded.

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Table 8
RECIPIENTS BY ELIGIBILITY CATEGORY, 1973-1982

Eligibility Category	Recipients (000) 1973	1982	Annual Growth Rate (%) 1973-79	1979-81	1981-82
TOTAL*	18,295	20,944	1.6	2.8	-1.4
With cash grants	14,602	16,602	1.3	3.1	-1.0
Without cash grants	3,693	4,342	2.6	1.9	-2.9
- - - - - - - - - - - - - - - -					
Aged	3,459	3,241	-.6	.7	-4.8
Blind	101	84	-3.8	3.7	-2.3
Disabled	1,798	2,784	6.5	4.0	-1.9
Children, AFDC	7,933	9,261	1.6	3.2	-0.1
Adults, AFDC	4,035	5,071	.9	7.4	3.4
Other Title XIX	969	783	1.7	-16.7	5.2

Sources: 1973 from NCSS document B-4; 1979, 1981, and 1982 from unpublished HCFA data Forms 2082. Puerto Rico and Virgin Islands are excluded.

*The total includes some people in more than one category at different times during the year. Since 1981, an unduplicated total has been reported which is about 3% less than the cruder totals.

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Figure 4 displays the relationship between payment levels and numbers of recipients for each of the four major eligibility categories. AFDC children, who account for approximately 45 percent of Medicaid recipients, spend only 12 percent of Medicaid dollars. It is also interesting to note that despite the aging of the U.S. population, the share of Medicaid recipients who are aged as opposed to those who are children has been decreasing.

Given the predominant role of the aged and disabled in the growth of Medicaid payments, we turn to a more detailed examination of their expenditures over time.

Table 9 provides data for the aged on recipients, payments and payments per recipient in 1975 and 1982, broken down by whether the recipients received cash grants, were eligible for but did not receive cash or were medically needy. The last two categories are the more costly cases, individuals receiving Medicaid benefits because of large medical bills.

Note that the 11.2 percent decrease in the number of aged recipients between 1975 and 1982 is comprised of a decrease of 24.1 percent in the number of cash recipients and an increase of 15.8 percent in the number of non-cash grant recipients. Since the non-cash grant aged recipients required almost $6000 in payments per recipient in 1982, as compared to slightly less than $1500 per aged cash recipient, this shift in the mix of patients explains why dollar payments have not decreased more in parallel with decreasing numbers of aged recipients.

As to why there is such a large drop in aged cash recipients given the aging of the population, this might be explained by increased Social Security benefits, private pension funds and other private assets. Using conventional definitions of poverty (including pension income), there was an increase in elderly poor persons from 3.3 million in 1975 to 3.8 million in 1981. However, the ratio of assets to income may have increased, and state policies might have changed their definition of income and passively restrained eligibility by not raising income cutoffs at the same rate as actual income was growing. This is discussed in Section 4 below.

Table 10 shows the percentage of Medicaid payments spent by the aged on the major service categories in 1975 and 1982. The high proportions of institutional LTC in the non-grant subgroups are the apparent determinant of the differences in expense per recipient found in Table 9. Nursing home services accounted for 78 percent of the medically needy aged payments and 87% of the categorical no-grant aged payments. However, note that payments to hospitals consumed a growing

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Figure 4
Shares of Total Payments and Recipients
By Eligibility

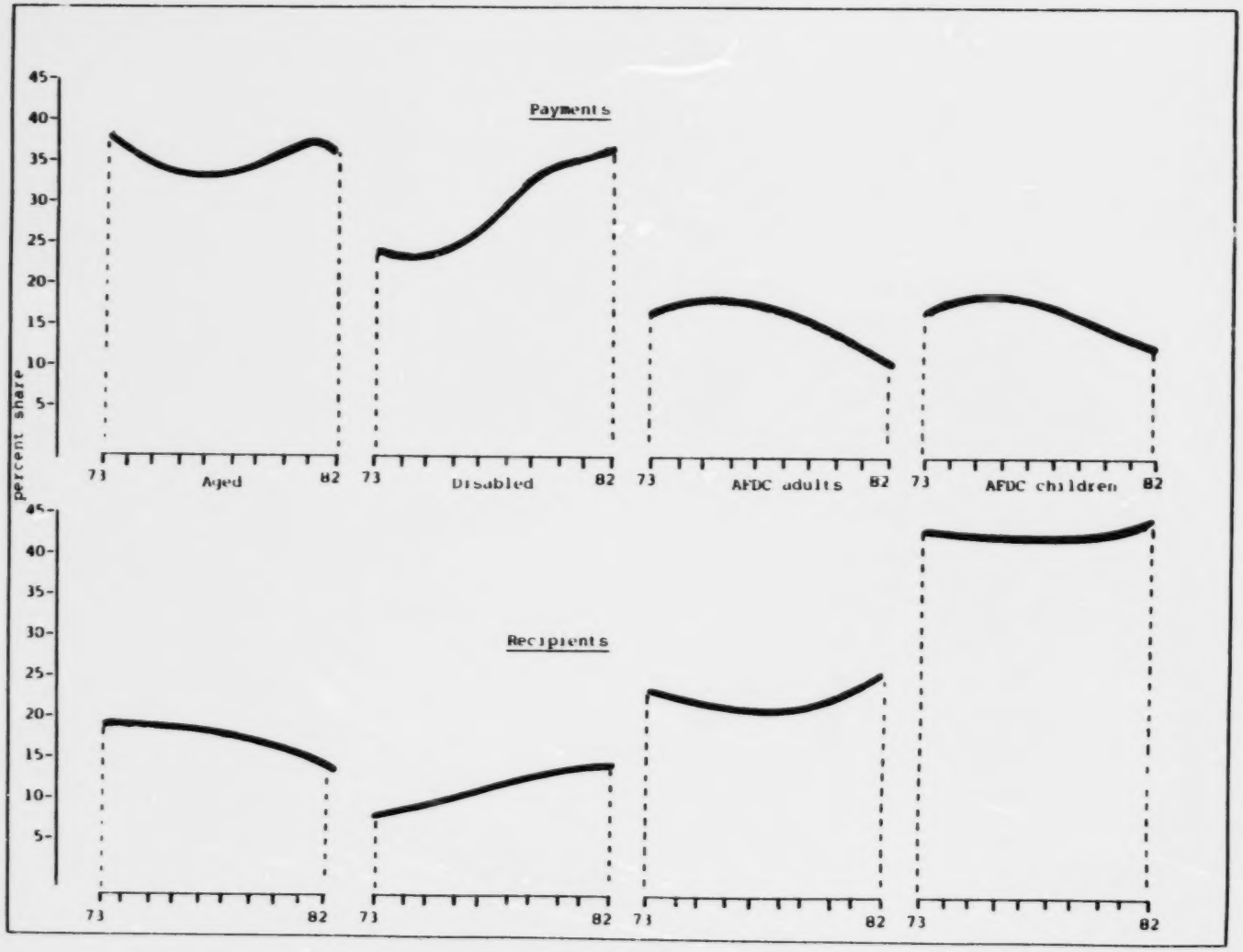

Table 9
AGED Recipients,
Detailed Breakdown By Basis Of Eligibility, 1975 AND 1982

	1975	1982	% Change
Recipients (000)			
All aged recipients	3,648	3,241	-11%
cash recipient	2,461	1,867	-24%
eligible, no grant	557	627	+13%
medically needy	630	747	+19%
Payments ($ million)			
All aged recipients	4,417	10,853	+146%
cash recipient	1,366	2,741	+101%
eligible, no grant	1,330	3,530	+165%
medically needy	1,721	4,582	+166%
Payment per Recipient ($)			
All aged recipients	1,211	3,350	+177%
cash recipient	555	1,469	+165%
eligible, no grant	2,388	5,630	+136%
medically needy	2,732	6,134	+125%

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Table 10
Proportion of Total Payments Spent on Selected Services,
for AGED Recipients, by Basis of Eligibility

Service	Cash Recipients 1975	Cash Recipients 1982	No Grant 1975	No Grant 1982	Medically Needy 1975	Medically Needy 1982	All Aged Recipients 1975	All Aged Recipients 1982
TOTAL	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Hospital Inpatient	.10	.19	.04	.02	.03	.10	.05	.10
ICF	.32	.28	.41	.58	.25	.29	.32	.38
SNF	.24	.14	.43	.29	.59	.49	.43	.34
Physicians	.07	.06	.02	.01	.01	.01	.03	.02
Hospital Outpatient	.01	.02	.00	.00	.00	.00	.00	.01
Drugs	.14	.12	.04	.05	.03	.03	.07	.06
SUBTOTAL	.89	.81	.94	.95	.91	.92	.91	.90
All Other	.11	.19	.06	.05	.09	.08	.09	.10

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share of total payments for the grant and medically needy aged.

Tables 11 and 12 present detailed data for recipients in the disabled category. The number of recipients in each subcategory of disabled increased between 1975 and 1982; the largest increase (66%) was for the cash-eligible no-grant group. Unlike the aged groups, for which a 177% increase in per capita costs was partially offset by a 11% decline in recipients, the disabled increased both in recipients (21%) and per capita costs (193%). This resulted in a 256% increase in total payments for the disabled, as compared to a 146% increase for the aged.

The most notable feature of Table 12, is the increasing and now very major role played by ICF-MR. The percent of total payments that went for ICF-MR increased dramatically for all subcategories of disabled and it is now the major service category, accounting for 32.9% of total payments for the disabled. To the extent that these Medicaid payments have replaced state payments for the institutionalized mentally retarded, this increase in Medicaid payments may in fact represent a reduced burden for states, which now can obtain matching federal support for these services.

3.0 PAYMENTS AND RECIPIENTS AT THE STATE LEVEL

3.1 Introduction

The objectives of this section are to document trends in individual state Medicaid payments, to examine whether national trends are dominated by a few states and to describe areas in which a substantial number of the states were able to lower Medicaid payment growth in 1981-1982.

In examining individual state experience , it is important to recognize that demographic and economic trends and medical care supply characteristics can affect state Medicaid payments independently of state policy. Further, the quality of medical services provided and the effect on the health of the poor of individual state policies are important areas of concern that are beyond the scope of this report. Finally, as noted in Section 1, state Medicaid expenditures (eligible for federal matching funds) account for less than 50% of total state expenditures on personal health care. Medicaid expenditures may either substitute for or complement other health expenditures. Thus, one must be cautious in inferring total state effort and costs of care on the basis of Medicaid payments. For example, increases in Medicaid payments

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Table 11
DISABLED Recipients,
Detailed Breakdown By Basis Of Eligibility, 1975 AND 1982

	1975	1982	% Change
Recipients (000)			
All disabled recipients	2,292	2,784	+21%
cash recipient	1,844	2,192	+19%
eligible, no grant	149	247	+66%
medically needy	299	345	+15%
Payments ($ million)			
All disabled recipients	2,948	10,496	+256%
cash recipient	1,985	6,628	+234%
eligible, no grant	313	1,457	+365%
medically needy	650	2,411	+271%
Payment per Recipient ($)			
All disabled recipients	1,287	3,770	+193%
cash recipient	1,076	3,023	+181%
eligible, no grant	2,103	5,899	+181%
medically needy	2,174	6,998	+222%

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Table 12
Proportion of Total Payments Spent on Selected Services,
for DISABLED Recipients, by Basis of Eligibility

Service	Cash Recipients 1975	Cash Recipients 1982	No Grant 1975	No Grant 1982	Medically Needy 1975	Medically Needy 1982	All Disabled Recipients 1975	All Disabled Recipients 1982
TOTAL	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Hospital								
Inpatient	.36	.29	.16	.13	.35	.23	.34	.25
ICF-MR	.08	.28	.21	.45	.06	.39	.09	.33
ICF-all other	.13	.06	.24	.20	.14	.08	.14	.08
SNF	.10	.04	.23	.11	.28	.11	.15	.07
Physicians	.09	.06	.04	.02	.05	.02	.08	.05
Hospital								
Outpatient	.03	.05	.02	.01	.01	.02	.02	.04
Drugs	.08	.06	.04	.03	.04	.02	.07	.05
SUBTOTAL	.87	.84	.94	.95	.93	.87	.89	.86
All Other	.13	.16	.06	.05	.07	.13	.11	.14

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for ICF-MR services may be partially offset by declines in other state expenses on mental health facilities.

Given these objectives and limitations, this chapter proceeds as follows. First, the overall payment and recipient levels and growth are reported and discussed for the period 1973 to 1982. Medicaid payments are then related to overall state expenditures and other variables for the most recent period for which data are available. Payment growth rates are then examined for specific sub-periods between 1973 and 1982, with particular attention on the extent to which the overall decrease in payment growth is widely reflected among the states. Medicaid payments by state for the major service and eligibility categories are then examined.

3.2 Overall State Trends

Table 13 provides fiscal year state Medicaid vendor payments for 1973 and 1982, state share of national Medicaid payments, average annual growth rate between 1973 and 1982 and the percent of total growth in payments over this period accounted for by each state. The states are ranked by 1982 total Medicaid payments in this and all succeeding tables.

Clearly, state ranking on total payments is closely related to state size, but with some notable exceptions. This point can be seen by comparing the two largest states. California is somewhat larger than New York in population but had Medicaid payments less than 60 percent of those for New York ($3.537 billion vs. $6.092 billion, respectively). The average annual growth rate for each state will determine whether the share of national expenditure will be rising or falling in this period. Note that the top five states in 1973 accounted for 54.6 percent of Medicaid payments, but only 43.6 percent of the growth in Medicaid payments between 1973 and 1982, resulting in a 46.7 percent share of total payments in 1982. New York, in particular, substantially reduced its share of total Medicaid payments, from 26.5 to 20.5 percent of total U.S. payments, although it still dwarfs other state Medicaid programs. No state had a growth rate under 10 percent per year while 13 states grew at rates exceeding 20 percent per annum.

Table 14 completes the overall picture of Medicaid growth, presenting total number of recipients, the percent of total recipients accounted for by each state, and the average dollar payments per recipient for 1973 and 1982. Note that despite an overall U.S. increase in recipients of 14.5 percent from 1973 to 1982, the number of recipients in New York declined by 15.5 percent over this period (2.786

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Table 13

Medicaid Payments, 1973-82
(States Ranked in Descending Order by 1982 Total Payments)

	Total Payments ($million)		Share of National (%)		Annual Growth Rate (%)	Share of National Growth (%)	Total Population
	1973	1982	1973	1982	1973-82	1973-82	(000)
ALL STATES	8543	29787	100.0	100.0	14.8	100.0	226546
NEW YORK	2261	6092	26.5	20.5	11.6	18.0	17558
CALIFORNIA	1088	3537	12.7	11.9	14.0	11.5	23668
PENNSYLVANIA	406	1652	4.8	5.5	16.9	5.9	11864
ILLINOIS	481	1344	5.6	4.5	12.1	4.1	11427
MICHIGAN	427	1293	5.0	4.3	13.1	4.1	9262
OHIO	221	1227	2.6	4.1	21.0	4.7	10798
MASSACHUSETTS	380	1207	4.5	4.1	13.7	3.9	5737
TEXAS	336	1158	3.9	3.9	14.7	3.9	14229
NEW JERSEY	249	875	2.9	2.9	15.0	2.9	7365
WISCONSIN	184	821	2.2	2.8	18.1	3.0	4706
MINNESOTA	182	796	2.1	2.7	17.8	2.9	4076
LOUISIANA	81	578	.9	1.9	24.4	2.3	4206
GEORGIA	178	570	2.1	1.9	13.8	1.8	5463
FLORIDA	98	553	1.1	1.9	21.2	2.1	9746
INDIANA	126	495	1.5	1.7	16.5	1.7	5490
NORTH CAROLINA	108	483	1.3	1.6	18.1	1.8	5882
VIRGINIA	107	473	1.3	1.6	18.0	1.7	5347
TENNESSEE	69	464	.8	1.6	23.6	1.9	4591
WASHINGTON	139	426	1.6	1.4	13.3	1.4	4132
MARYLAND	171	418	2.0	1.4	10.4	1.2	4217
MISSOURI	68	384	.8	1.3	21.2	1.5	4917
OKLAHOMA	115	362	1.3	1.2	13.6	1.2	3025
CONNECTICUT	119	358	1.4	1.2	13.1	1.1	3108
KENTUCKY	74	341	.9	1.1	18.6	1.3	3661
ALABAMA	80	338	.9	1.1	17.4	1.2	3894
IOWA	37	287	.4	1.0	25.6	1.2	2914
SOUTH CAROLINA	45	279	.5	.9	22.5	1.1	3122
ARKANSAS	46	267	.5	.9	21.7	1.0	2286
MISSISSIPPI	56	263	.7	.9	18.8	1.0	2521
COLORADO	74	244	.9	.8	14.2	.8	2890
KANSAS	74	233	.9	.8	13.7	.8	2364
RHODE ISLAND	58	201	.7	.7	14.9	.7	947
OREGON	32	188	.4	.6	21.9	.7	2633
DIST. OF COLUMBIA	63	179	.7	.6	12.3	.5	638
MAINE	43	178	.5	.6	17.0	.6	1125
NEBRASKA	41	135	.5	.5	14.1	.4	1570
HAWAII	31	125	.4	.4	16.9	.4	965
WEST VIRGINIA	26	121	.3	.4	18.6	.4	1950
UTAH	25	98	.3	.3	16.3	.3	1461
NEW MEXICO	20	97	.2	.3	19.2	.4	1303
NEW HAMPSHIRE	11	87	.1	.3	25.3	.4	921
MONTANA	17	87	.2	.3	19.8	.3	787
VERMONT	24	78	.3	.3	13.9	.3	511
SOUTH DAKOTA	15	77	.2	.3	20.2	.3	691
NORTH DAKOTA	15	66	.2	.2	17.8	.2	653
NEVADA	12	65	.1	.2	21.1	.3	800
IDAHO	16	64	.2	.2	16.5	.2	944
DELAWARE	11	56	.1	.2	19.6	.2	594
ALASKA	3	50	.0	.2	35.4	.2	402
WYOMING	4	19	.0	.1	18.9	.1	470

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Table 14

Medicaid Recipients and Payments Per Recipient 1973-82
(States Ranked in Descending Order by 1982 Total Payments)

	Total Recipients (000)		Share of National (%)		Payment per Recipient ($)	
	1973	1982	1973	1982	1973	1982
ALL STATES	20944	18295	100.0	100.0	467	1422
NEW YORK	2786	2353	15.2	11.6	811	2589
CALIFORNIA	3009	3748	16.5	18.4	362	944
PENNSYLVANIA	1281	1098	7.0	5.4	317	1504
ILLINOIS	1226	1063	6.7	5.2	392	1264
MICHIGAN	749	1175	4.1	5.8	570	1100
OHIO	578	878	3.2	4.3	383	1397
MASSACHUSETTS	728	670	4.0	3.3	523	1803
TEXAS	672	676	3.7	3.3	500	1712
NEW JERSEY	533	636	2.9	3.1	467	1375
WISCONSIN	305	460	1.7	2.3	605	1785
MINNESOTA	241	323	1.3	1.6	755	2461
LOUISIANA	253	389	1.4	1.9	320	1486
GEORGIA	445	438	2.4	2.2	399	1301
FLORIDA	311	520	1.7	2.6	314	1064
INDIANA	224	238	1.2	1.2	561	2076
NORTH CAROLINA	293	354	1.6	1.7	368	1365
VIRGINIA	278	319	1.5	1.6	385	1481
TENNESSEE	217	363	1.2	1.8	318	1279
WASHINGTON	292	253	1.6	1.2	476	1683
MARYLAND	415	323	2.3	1.6	413	1292
MISSOURI	324	338	1.8	1.7	211	1137
OKLAHOMA	224	243	1.2	1.2	512	1490
CONNECTICUT	178	198	1.0	1.0	668	1813
KENTUCKY	341	353	1.9	1.7	217	968
ALABAMA	259	322	1.4	1.6	308	1051
IOWA	124	180	.7	.9	298	1600
SOUTH CAROLINA	165	250	.9	1.2	274	1115
ARKANSAS	110	196	.6	1.0	416	1358
MISSISSIPPI	254	304	1.4	1.5	219	866
COLORADO	152	144	.8	.7	487	1699
KANSAS	148	148	.8	.7	496	1576
RHODE ISLAND	108	124	.6	.6	535	1622
OREGON	131	166	.7	.8	241	1134
DISTR. OF COLUMBIA	140	108	.8	.5	450	1650
MAINE	89	127	.5	.6	487	1399
NEBRASKA	69	78	.4	.4	595	1735
HAWAII	80	102	.4	.5	382	1225
WEST VIRGINIA	141	178	.8	.9	185	679
UTAH	60	60	.3	.3	416	1644
NEW MEXICO	65	91	.4	.4	309	1076
NEW HAMPSHIRE	41	44	.2	.2	281	1979
MONTANA	36	53	.2	.3	474	1631
VERMONT	43	54	.2	.3	562	1446
SOUTH DAKOTA	27	36	.1	.2	542	2157
NORTH DAKOTA	28	31	.2	.2	535	2121
NEVADA	21	29	.1	.1	547	2284
IDAHO	34	40	.2	.2	471	1594
DELAWARE	48	48	.3	.2	233	1157
ALASKA	6	26	.0	.1	569	1964
WYOMING	10	12	.1	.1	421	1558

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million to 2.353 million). Overall, 39 of the states had increases in the number of recipients while 11 had decreases.

Table 14 also shows the variation across states in payments per recipient. This variation is difficult to interpret without extended analysis of eligibility, service coverage, payment policies, and demographic composition of the state. For illustrative purposes, it is worth paying some attention to the remarkable difference in payments per recipient between New York and California ($2589 vs. $944). There are at least three contributing hypotheses that should be considered. First, the number of recipients may be overcounted in both states because the programs are operated by counties and when people move they may receive new identification numbers (a reportedly more serious problem in California). This would apply especially to AFDC eligibles, since most elderly and disabled are identified by federal reporting systems. These two states had recipients per capita of 13% and 14.4% respectively, compared to 10.2% for all states. Even if the number of California recipients were overestimated by 4% of population, this would reduce the gap between the two states ($1645) by less than 20%.

Another related hypothesis is that California is serving relatively more AFDC recipients and fewer aged and disabled than is New York. This appears to be a minor factor. Aged recipients are 15% of the total in California versus 16% in New York. Disabled recipients are 14% of the total in each state.

A third hypothesis is that California pays for much less expensive long-term care within the Medicaid program for reasons that are not fully understood. It turns out that payments to long-term care facilities are 20.3% of total payments in California compared to 41.8% in New York. This difference is traceable to the relatively small amounts spent on ICF care in and California, which is believed to be partially offset by in-home services and by other expenses by non-Medicaid programs in that state. A contributing factor is that average daily payment rates to long term care facilities were one-half to two-thirds as high in California as in New York (see Table 24 below)

Other overall contrasts between states are shown in Table 15, which provides data for the most recent year available on (1) Medicaid payments as a share of total personal health care expenses (1978); (2) Medicaid share of the state's general operating expenses (1981); (3) Medicaid share of state personal income (1981); (4) number of Medicaid recipients per capita (1980) and (5) number of recipients divided by the number of individuals below the poverty line (1979).

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Table 15
Medicaid Payments and Recipients as Shares of
Various State Totals
(States Ranked in Descending Order by 1982 Total Payments)

	Medicaid Share of: PHCE 1978 (%)	SGOE 1981 (%)	PY 1981 (%)	per capita 1980	Recipients per poor person 1979
All States	12.0	5.4	1.1	.102	.82
NEW YORK	22.0	11.3	2.6	.130	1.028
CALIFORNIA	11.7	4.9	1.2	.144	1.285
PENNSYLVANIA	13.0	5.0	1.0	.105	1.149
ILLINOIS	10.7	5.6	1.0	.092	.825
MICHIGAN	12.2	5.7	1.2	.105	.949
OHIO	7.7	4.6	.9	.075	.666
MASSACHUSETTS	13.4	7.4	1.7	.135	1.967
TEXAS	8.2	4.0	.7	.050	.335
NEW JERSEY	10.1	4.7	.9	.092	.962
WISCONSIN	14.4	5.8	1.7	.090	1.055
MINNESOTA	14.3	5.5	1.5	.080	.812
LOUISIANA	11.0	2.6	1.1	.091	.508
GEORGIA	10.8	3.5	1.1	.079	.455
FLORIDA	3.7	2.6	.5	.051	.339
INDIANA	7.4	3.6	.8	.037	.439
NORTH CAROLINA	8.6	2.6	.9	.064	.463
VIRGINIA	8.1	3.3	.8	.060	.508
TENNESSEE	9.0	3.4	1.1	.077	.441
WASHINGTON	9.1	3.7	.9	.076	.691
MARYLAND	7.3	3.4	.7	.074	.725
MISSOURI	5.2	3.7	.8	.065	.581
OKLAHOMA	10.5	3.9	1.1	.084	.654
CONNECTICUT	9.9	5.8	.9	.084	.904
KENTUCKY	10.5	2.7	1.2	.112	.650
ALABAMA	7.8	2.1	.9	.083	.455
IOWA	8.6	3.7	.9	.061	.591
SOUTH CAROLINA	10.8	2.4	1.0	.108	.496
ARKANSAS	13.7	3.4	1.5	.097	.503
MISSISSIPPI	12.0	2.0	1.3	.122	.471
COLORADO	8.0	3.4	.7	.054	.528
KANSAS	9.1	4.2	.8	.063	.647
RHODE ISLAND	15.4	6.1	1.9	.135	1.308
OREGON	8.4	2.7	.7	.105	.823
DISTRICT OF COL	99.9	4.0	1.9	.199	1.162
MAINE	14.0	3.8	1.5	.129	1.112
NEBRASKA	7.3	3.5	.8	.045	.426
HAWAII	11.9	3.3	1.0	.111	1.198
WEST VIRGINIA	6.7	1.8	.8	.066	.362
UTAH	8.5	1.9	.8	.039	.449
NEW MEXICO	7.0	1.4	.8	.067	.379
NEW HAMPSHIRE	9.6	3.9	.9	.049	.586
MONTANA	10.0	2.9	.9	.058	.446
VERMONT	14.9	3.7	1.6	.105	.832
SOUTH DAKOTA	11.5	2.7	1.1	.050	.310
NORTH DAKOTA	7.0	2.7	.9	.048	.365
NEVADA	4.5	3.4	.6	.032	.317
IDAHO	7.7	2.0	.7	.047	.352
DELAWARE	7.0	2.9	.8	.083	.656
ALASKA	7.3	.9	.8	.044	.420
WYOMING	4.2	.9	.3	.024	.310

PHCE = Total Personal Health Care in the State
SGOE = State General Operating Expenses
PY = Personal Income

(for sources, see Table 3)

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New York is seen to score very high on all these measures of relative Medicaid expenditures. As later tables indicate, New York does not appear to differ greatly from the national average with regard to the proportion of payments going for the elderly or the disabled or for institutional care. In Table 15, the ratios of Medicaid payments to income and to per capita health expense may be interpreted as showing a wide variation across states in the willingness to commit resources to Medicaid, and an especially high general commitment in New York. Among the larger states, Texas and Florida are notable for their low ratio of recipients to individuals classified as poor (.335 and .339 respectively). Arizona, Wyoming, Nevada and Florida stand out as states that allocated the lowest percentages of personal income to Medicaid (0, .3%, .5%, and .6% respectively), resulting in a combination of very low recipient levels, relative to the number of poor in the state, and very low allocations of total health expenditures to Medicaid.

Because Medicaid represents only a part of a state's expenses for health care, the following questions become important: (1) Do states using a higher than average share of their total budgets for Medicaid use a lower than average share for other health care? (2) Has the overall high growth in Medicaid expenses been offset by lower growth of expenses for other state health care programs?

While definitive answers to these questions cannot be given, some evidence is obtained from U.S. Census Bureau annual publications of Government Finances. For 1980, Table 16 compares budget shares for vendor health payments versus other hospital and health expenses. While vendor payments include some non-Medicaid expenses, the data show that wide variation in budget share of vendor payments is not associated with offsetting variation in other hospital and health expenses. A comparison of growth rates between 1974 and 1980 revealed that hospital and health expenses in total did not decline as a share of state budgets, despite the rising share of Medicaid. However, while total state spending grew by 11.8% per year and Medicaid grew at the rate of 17%, state spending on mental health facilities grew at only the rate of 9.6%. This comparison was in the direction expected, but it is not large in view of the importance of ICF-MR expenditure growth in the overall Medicaid experience.

The decrease in the growth of payments from 1981 to 1982, reported in the last chapter, is not restricted to just a few states. Table 17 makes this point clear by contrasting a relatively constant growth in the medical component of the consumer price index with a substantial increase in the number of states experiencing low or negative growth rates from 1981 to 1982 as compared to 1980-81 or 1979-80. The number

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Table 16
BUDGET SHARES FOR STATE HEALTH CARE EXPENSES

Health Vendor Payments as Percent of State Expenditures	Number of States	Average	Average Budget Share for Other Health Expenses
0 - 4.9%	9	3.0%	5.1%
5.0 - 5.9	9	5.3	6.5
6.0 - 6.9	10	6.6	7.4
7.0 - 7.9	7	7.5	7.6
8.0 - 8.9	3	8.4	7.4
9.0 - 9.9	8	9.4	6.7
10.0 +	4	11.5	7.2

Source: U.S. Bureau of the Census, Government Finances, GF80 No. 3, August 1981.

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Table 17
NUMBER OF STATES BY GROWTH RATE INTERVAL
GROWTH OF TOTAL PAYMENTS, 1979-82

Growth Rate	1979-80	1980-81	1981-82
negative	1	1	7
0-5%	3	4	9
5-10%	2	4	12
10-15%	15	9	12
over 15%	29	32	10
ALL STATES	50	50	50
Addendum:			
Growth rate of CPI-M	10.8%	11.4%	10.8%

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of states experiencing growth rates above 15 percent dropped by two-thirds (from 32 to 10) while the number with less than a five percent growth rate tripled (5 to 16). The mean growth rate in 1981-82, in fact, also represented the median growth rate for this period. Thus, overall trends appear to reflect widespread changes among states rather than the experience of a few large states.

These do not, however, represent uniformity among states as the variation in growth rates among states was far greater for 1981-82 than in past years. The coefficient of variation[12], a standard measure of dispersion, was .96 for 1981-82, as compared to .57 and .54 for the two prior years. The coefficient of variation for the level of payments across states has declined over time, falling from 2.06 in 1973 to 1.61 in 1979, but increasing slightly to 1.66 in 1982. A similar pattern occurred for the variation in number of recipients. This is consistent with the view that some states made substantial changes in Medicaid policy, at least partially aided by changes in federal legislation embodied in OBRA, while other states have not reacted as much or as soon.

Tests for association between state policy change, outside influences (e.g., unemployment) and changes in expenditure growth can be conducted by a variety of methods. The emphasis here is on classifying states regarding slowdown of expenditure growth relative to other states. This classification will identify states where one should expect to find major policy changes or environmental changes. In Section 4 below, states will be compared according to changes in selected program characteristics and these rankings will then be compared with the expenditure changes.

Figure 5 divides states into tertiles of expenditure growth for the periods 1973-81 and 1981-82. Each tertile for 1981-82 represents slower growth than the corresponding tertile of 1973-81. Policies and outside factors leading to the general slowdown in all states are, roughly speaking, controlled. The off-diagonal clusters are of primary interest for further investigation. Eight states went from relatively high to relatively low growth rates, while five states had the opposite results. If policy changes are a major cause of the slowdown for FY82, these two clusters of states are expected to differ substantially in the undertaking (or not undertaking) of policy changes. This hypothesis

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[12]The coefficient of variation is defined as the standard error divided by the mean.

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Figure 5

Clustering of States By Recent Versus Trend Growth Rates

TOTAL Payments

1973-81 Average Annual Growth Rate (%)	1981-82 Growth Rate (%) Low (under 5.1)	Middle (6.2 - 11.2)	High (over 11.5)
Low (under 15.7)	California Connecticut Illinois Michigan Oklahoma Washington	Georgia Kansas Massachusetts Nebraska New Jersey Vermont	Colorado Maryland New York Pennsylvania Washington, D.C.
Middle (15.8-20.7)	North Carolina Texas Utah	Idaho Mississippi New Mexico North Dakota Rhode Island Virginia	Alabama Hawaii Indiana Maine Minnesota Montana Wyoming
High (over 20.7)	Arkansas Iowa Kentucky Missouri Oregon South Carolina West Virginia Wisconsin	Delaware Nevada New Hampshire Tennessee	Alaska Florida Louisiana Ohio South Dakota

will be tested for specific services in Section 4.5 below.

3.3 Payments and Recipients for Selected Services

In Section 2, we noted that hospital payments (inpatient and outpatient) and nursing home payments (all types) were the largest service categories, in terms of Medicaid payments, accounting for 31.2 and 43.5 percent of total Medicaid payments, respectively. They are also the two fastest growing major service groups. We therefore focus more attention on these service categories while recognizing that physician reimbursement rates and policies can also influence the use of hospital and long term care facilities -- directly by their medical decisions, and indirectly by their willingness to accept and treat Medicaid patients in the office setting rather than referring patients to hospitals.

Table 18 lists 1982 state Medicaid payments and share of total state payments that go to hospitals and nursing homes, plus the annualized growth rate in payments for each of these sectors between 1975 and 1982. Figures 6 and 7 cluster states by hospital and nursing home growth, respectively, comparing growth from 1975 to 1981 with 1981-82 growth.

Two questions of interest are whether the variation in hospital payments growth across states is more or less than the variation in nursing home payment growth and whether states with high (low) growth in hospital payments have high (low) growth in nursing home payments. The variation in growth rates (1975-82) across states is, in fact, quite similar for the hospital and nursing home sectors. The coefficient of variation is .28 for hospital payments growth and .32 for nursing home payment growth. However, few states, only 13, are in the same row and column in Figures 6 and 7. The correlation between hospital and nursing home growth (excluding ICF/MR) for the two years 1975 and 1982 was only .3. Thus, state factors that tend to limit or exacerbate the growth in Medicaid hospital payments during a given period did not have a commensurate impact on nursing homes, relative to other states, and visa versa. On the other hand, there was no general "substitution" of one category of service for another. The differences in hospital and in nursing home payments across states appear to raise some independent questions for research. Explanations of Medicaid growth are likely to be unsatisfactory unless they are sufficiently disaggregated to explain changes in the individual major service categories.

The extent to which the growth in Medicaid payments is accounted for by just a few of the largest growing states is presented in

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Table 18

Medicaid Hospital and Nursing Home Payments, 1975-82
(States Ranked in Descending Order by 1982 Total Payments)

	Hospital Payments ($million) 1982	Share of State Total 1982	Annual Growth Rate 1975-82	Nursing Facility* Payments ($million) 1982	Share of State Total 1982	Annual Growth Rate 1975-82
ALL STATES	9302	31.2%	13.9%	12970	43.5%	15.7%
NEW YORK	1914	31.4	11.3	2546	41.8	13.1
CALIFORNIA	1454	41.1	14.3	719	20.3	11.0
PENNSYLVANIA	443	26.8	9.9	889	53.8	12.6
ILLINOIS	493	36.7	11.0	518	38.5	15.5
MICHIGAN	426	33.0	11.5	482	37.3	12.7
OHIO	458	37.3	18.5	498	40.6	23.6
MASSACHUSETTS	500	41.4	20.8	501	41.5	11.8
TEXAS	249	21.5	16.6	632	54.6	13.7
NEW JERSEY	276	31.6	14.2	388	44.3	18.9
WISCONSIN	157	19.1	14.6	490	59.7	12.5
MINNESOTA	136	17.1	15.7	522	65.6	19.4
LOUISIANA	137	23.8	22.6	310	53.6	24.3
GEORGIA	181	31.8	13.5	243	42.6	13.6
FLORIDA	205	37.0	21.9	229	41.4	18.8
INDIANA	127	25.7	17.8	224	45.3	14.1
NORTH CAROLINA	136	28.1	12.7	244	50.6	26.0
VIRGINIA	132	27.9	14.2	242	51.2	22.9
TENNESSEE	123	26.4	22.8	211	45.5	20.9
WASHINGTON	99	23.2	9.9	231	54.2	20.0
MARYLAND	164	39.1	8.3	192	46.0	23.3
MISSOURI	123	32.0	16.2	191	49.8	37.7
OKLAHOMA	96	26.5	13.7	177	48.9	12.4
CONNECTICUT	80	22.3	7.6	217	60.4	15.0
KENTUCKY	99	29.0	16.3	156	45.6	26.2
ALABAMA	96	28.4	17.9	153	45.3	14.1
IOWA	70	24.2	22.3	155	53.8	20.1
SOUTH CAROLINA	69	24.7	18.3	144	51.8	26.7
ARKANSAS	52	19.4	20.8	152	56.9	15.7
MISSISSIPPI	79	29.9	18.0	119	45.2	21.0
COLORADO	58	23.9	13.0	127	52.1	14.5
KANSAS	61	26.3	11.8	116	49.9	15.8
RHODE ISLAND	80	39.7	14.1	97	48.1	22.5
OREGON	41	21.6	12.9	105	56.0	15.0
DIST. OF COLUMBIA	111	62.2	10.8	30	16.6	16.5
MAINE	51	28.9	15.9	92	51.6	21.1
NEBRASKA	31	22.9	16.6	74	55.2	13.5
HAWAII	31	25.0	17.0	58	46.7	23.9
WEST VIRGINIA	50	41.2	20.9	43	35.4	37.5
UTAH	25	25.9	19.5	52	52.8	19.1
NEW MEXICO	35	36.4	19.5	35	36.3	23.5
NEW HAMPSHIRE	13	15.4	12.2	58	67.3	24.2
MONTANA	20	23.1	17.8	46	53.5	19.7
VERMONT	17	21.4	12.1	40	51.2	17.7
SOUTH DAKOTA	17	21.5	21.8	46	60.0	19.8
NORTH DAKOTA	13	20.0	14.4	38	58.2	19.2
NEVADA	24	37.2	23.0	28	43.1	27.7
IDAHO	14	21.5	17.1	38	60.6	15.6
DELAWARE	18	33.0	18.4	25	45.3	30.9
ALASKA	11	21.1	28.0	33	65.6	30.8
WYOMING	6	30.6	26.1	11	56.5	20.8

*Includes SNF, ICF, and ICF/MR

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Figure 6

Clustering of States By Recent Versus Trend Growth Rates

HOSPITAL Payments

1975-81 Average Annual Growth Rate (%)	1981-82 Growth Rate (%) Low (under 6.2)	Middle (6.3 - 14.7)	High (over 14.8)
Low (under 14.0)	Connecticut Illinois Michigan Maryland Vermont Washington	Colorado Virginia Washington, D.C. Wisconsin	Georgia Kansas Maine Minnesota New Jersey New York Pennsylvania
Middle (14.1 - 17.9)	California New Hampshire North Carolina North Dakota Oklahoma Oregon	Idaho Rhode Island Texas	Alabama Hawaii Indiana Louisiana Montana Nebraska Ohio
High (over 18.0)	Arkansas Kentucky Missouri Utah West Virginia	Delaware Florida Iowa Massachusetts Mississippi New Mexico Nevada South Carolina Tennessee	Alaska South Dakota Wyoming

Figure 7

Clustering of States By Recent Versus Trend Growth Rates

NURSING FACILITY Payments

1973-81 Average Annual Growth Rate (%)	1981-82 Growth Rate (%)		
	Low (under 9.0)	Middle (9.0 - 15.0)	High (over 15.0)
Low (under 17.2)	California Georgia Michigan Nebraska Oklahoma Oregon Wisconsin	Colorado Idaho Illinois Massachusetts	Alabama Connecticut Indiana New York Pennsyvlania Washington, D.C.
Middle (17.2-22.6)	Arkansas Iowa Kansas South Dakota Texas	New Jersey Washington	Florida Hawaii Maine Maryland Minnesota Mississippi Montana North Dakota Vermont
High (over 22.6)	Delaware Kentucky Rhode Island Utah Wyoming	Alaska Missouri Nevada New Hampshire New Mexico North Carolina South Carolina Tennessee Virginia West Virginia	Louisiana Ohio

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Figures 8 and 9, for 1975 to 1982 and for 1981 to 1982, respectively. The ten highest growth states for each of the selected service categories are named at the bottom of each figure.

To understand these figures, consider first growth in Medicaid payments between 1975 and 1982, presented for selected service categories in Figure 8. The vertical axis measures the share of total Medicaid payments growth accounted for by the n states with the highest payment growth for that service category between 1975 and 1982, where n is read from the horizontal axis. Thus, for total payments, the top five states accounted for approximately 45 percent of total payments growth between 1975 and 1982. By checking back with Table 13, one finds that the top few states accounting for national growth are nearly, but not exactly identical with the top states in size of program (e.g., two discrepancies in the top 5). This degree of conformity is to be expected, given the wide range of program size. Of further interest is whether the concentration for particular services differs from total expense, and whether the concentration changed in FY82. A payment curve that is rising faster than total payments for the first few states corresponds to a service sector where a few states account for a greater percentage of that sector's Medicaid payment growth than is true for Medicaid payments as a whole.[13]

Inpatient hospital and ICF-MR growth are seen to be about as concentrated among the states as is total payments. ICF payments are far less concentrated within a few states while SNF payments are far more concentrated. In fact, 13 states account for 100 percent of the growth of SNF payments between 1975 and 1982, with 25 states accounting for 107 percent of SNF growth. This means that some states had negative SNF growth rates over this period despite the high inflation rate. These ICF/SNF results may be due to an actual shift in the type of nursing home used (or a down grading of nursing homes) by many states, from SNFs to ICFs, or could partly reflect a change in classification for data reporting.

Figure 9 presents the same picture for 1981-82 growth in payments accounted for by the top growing states. Note that in this Figure all

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[13]Note that the data are shares of the national growth. If all states were displayed, the curves would end at 1.0 (100%). Therefore, while the curve for SNF services exceeds 1.0 for the first 25 states, negative growth in some of the remaining states brings the curve down to 1.0 after all states are included.

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Figure 8
State Shares in National Expenditure Growth
For Selected Service Categories
1975 - 1982

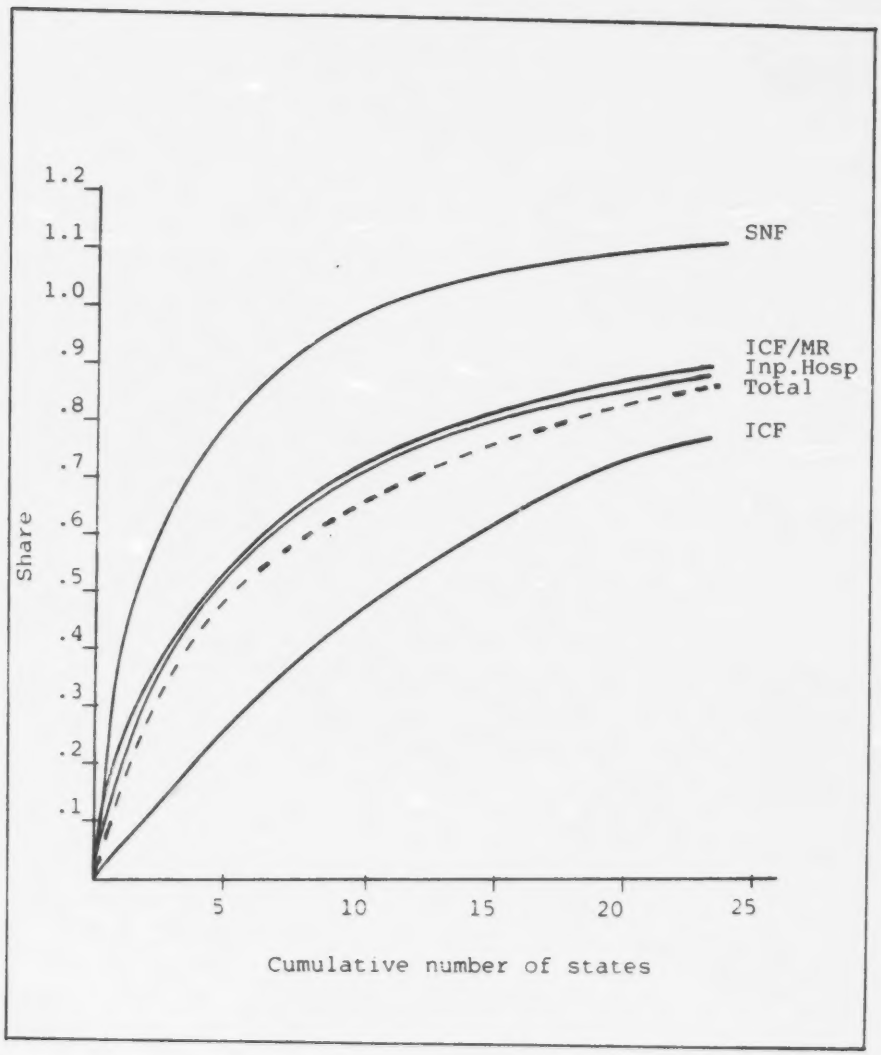

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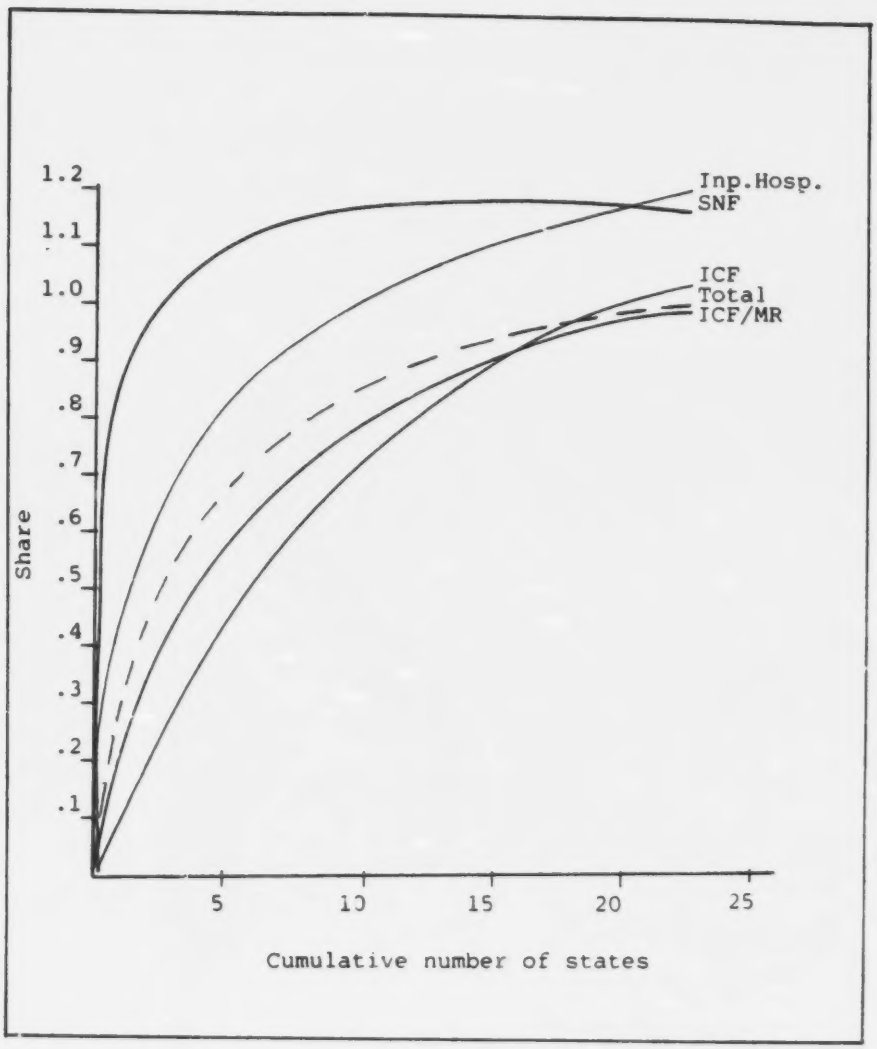
Figure 9
State Shares in National Expenditure Growth
For Selected Service Categories
1981 - 1982



curves are more "bowed out" (concave), reflecting, in part, a greater expected variation when looking at a single year. In addition, a larger number of states had low or negative growth in payments between 1981 and 1982, and most of the remaining growth was concentrated in a few states. Thus, 12 states account for the entire national growth in hospital payments over this last year, which means the other 38 states had zero average hospital payment growth in 1981-82.

3.4 Payments and Recipients for Selected Eligibility Categories

Table 19 presents payments, number of recipients, and dollars per recipient by state for the aged in 1982. It also displays the share of total state payments that goes to the elderly and average annual growth rates in payments and numbers of recipients between 1975 and 1982. The share of total Medicaid payments going to the aged ranged from 20.3 percent in the District of Columbia to 63.0 percent in New Hampshire. Almost half the states (25) had negative growth in the number of aged recipients during this period. However, from the discussion of aggregate data it is clear that when such a decline is concentrated among cash recipients as opposed to the far more expensive non-cash aged recipients, total Medicaid payments will not proportionately reflect this decline in recipients.

Table 20 presents the same variables by state for the disabled. Only 6 states had declining numbers of disabled recipients from 1975 to 1982. The share of state Medicaid payments going to the disabled in 1982 ranges from 16.8 percent in Wyoming to 42.1 percent in Nevada.

California had the second lowest level of payments per recipient for the aged (Alabama was lower) and sixth lowest payments per recipient for the disabled. While differences in these expenses can be traced primarily to institutional LTC, explanations for such large program differences have not been tested. This seems an excellent example of a topic warranting further research.

4.0 PROFILE OF STATE MEDICAID POLICIES AND RECENT CHANGES

This section begins with a brief description of the variation across states for 1982 in major Medicaid policies. Within the boundaries established by Title XIX of the Social Security Act, states set policy in 4 principal areas: eligibility criteria, covered services, payment of providers, and administration. Data are presented about selected state policies in each of these areas. Most of these

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Table 19

Medicaid AGED Payments and Recipients 1975-82
(States Ranked in Descending Order by 1982 Total Payments)

	Payments ($million) 1982	Share of State Total 1982	Recipts. (000) 1982	Dollars per Recipt. 1982	Payments Annual Growth Rate 1975-82	Recipts. Annual Growth Rate 1975-82
ALL STATES	10854	36.4%	3241	3349	13.7%	-1.7%
NEW YORK	2339	38.4	371	6307	14.0	-1.5
CALIFORNIA	870	24.6	570	1526	11.9	-1.6
PENNSYLVANIA	630	38.2	128	4909	11.6	3.3
ILLINOIS	275	20.4	76	3604	8.3	-4.8
MICHIGAN	328	25.4	91	3615	8.5	-2.4
OHIO	415	33.8	91	4565	13.1	-5.0
MASSACHUSETTS	569	47.1	81	7014	15.3	-6.7
TEXAS	531	45.8	235	2255	10.4	-.7
NEW JERSEY	313	35.8	60	5193	11.6	.7
WISCONSIN	320	39.0	54	5890	10.0	-7.8
MINNESOTA	358	45.0	52	6835	17.3	2.0
LOUISIANA	230	39.8	93	2471	17.2	-4.3
GEORGIA	196	34.5	95	2056	10.8	-2.4
FLORIDA	229	41.4	110	2082	15.9	3.5
INDIANA	199	40.1	37	5323	15.2	1.4
NORTH CAROLINA	194	40.2	74	2604	19.1	-2.8
VIRGINIA	204	43.2	62	3274	18.7	.5
TENNESSEE	178	38.4	82	2167	18.0	-.3
WASHINGTON	156	36.7	51	3061	14.2	3.7
MARYLAND	152	36.3	38	3986	17.3	-2.5
MISSOURI	171	44.4	69	2491	26.6	-3.8
OKLAHOMA	159	44.1	58	2761	14.2	-.3
CONNECTICUT	184	51.3	28	6449	15.6	2.4
KENTUCKY	118	34.6	59	2004	17.5	-3.8
ALABAMA	137	40.5	91	1499	9.3	-3.9
IOWA	105	36.5	30	3477	13.9	.3
SOUTH CAROLINA	111	39.7	49	2281	18.9	-7.6
ARKANSAS	113	42.6	56	2026	11.6	-3.5
MISSISSIPPI	117	44.6	69	1710	13.2	-3.1
COLORADO	96	39.5	37	2572	9.6	2.3
KANSAS	79	34.0	26	2993	14.6	2.5
RHODE ISLAND	97	48.1	23	4162	25.9	1.0
OREGON	65	34.6	19	3500	14.3	.5
DIST.OF COLUMBIA	36	20.3	11	3242	20.9	-.5
MAINE	81	45.4	21	3787	18.3	.5
NEBRASKA	56	41.8	15	3848	12.4	-.8
HAWAII	51	40.4	12	4323	21.2	2.9
WEST VIRGINIA	47	38.8	25	1873	31.6	2.9
UTAH	26	26.3	7	3699	15.0	3.0
NEW MEXICO	25	25.8	12	2055	20.0	2.7
NEW HAMPSHIRE	55	63.0	9	5872	22.1	-2.2
MONTANA	37	42.6	8	4595	17.7	.8
VERMONT	30	37.7	8	3851	11.5	-1.6
SOUTH DAKOTA	34	44.1	9	3784	15.0	-3.6
NORTH DAKOTA	40	60.0	11	3656	17.4	7.5
NEVADA	23	35.4	6	3621	22.2	6.2
IDAHO	24	37.1	7	3623	13.7	1.0
DELAWARE	20	35.0	5	4104	22.8	1.2
ALASKA	21	41.2	4	5481	31.3	19.8
WYOMING	10	54.6	2	4167	23.1	4.2

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Table 20

Medicaid DISABLED Payments and Recipients, 1975-82
(States Ranked in Descending Order by 1982 Total Payments)

	Payments ($million) 1982	Share of State Total 1982	Recipts. (000) 1982	Dollars per Recipt. 1982	Payments Annual Growth Rate 1975-82	Recipts. Annual Growth Rate 1975-82
ALL STATES	10495	35.2	2784	3770	19.9	2.8
NEW YORK	2415	39.6	336	7183	18.5	.9
CALIFORNIA	1208	34.2	532	2273	15.6	1.4
PENNSYLVANIA	588	35.6	127	4640	23.5	3.9
ILLINOIS	550	40.9	136	4058	14.8	-5.0
MICHIGAN	447	34.6	120	3739	16.4	4.9
OHIO	388	31.7	95	4095	58.1	25.3
MASSACHUSETTS	347	28.7	69	5025	18.5	1.3
TEXAS	419	36.2	105	3994	24.9	4.5
NEW JERSEY	251	28.7	63	3988	24.9	2.1
WISCONSIN	263	32.0	46	5655	14.3	.8
MINNESOTA	281	35.4	29	9600	19.6	3.9
LOUISIANA	227	39.3	64	3559	29.3	4.6
GEORGIA	232	40.8	91	2565	19.1	6.5
FLORIDA	189	34.2	94	2022	25.9	8.6
INDIANA	192	38.8	32	5920	22.7	6.6
NORTH CAROLINA	161	33.4	47	3460	15.9	-6.1
VIRGINIA	151	32.1	47	3236	21.6	5.0
TENNESSEE	173	37.3	79	2191	25.6	7.0
WASHINGTON	171	40.1	52	3304	19.8	3.5
MARYLAND	118	28.2	34	3506	19.6	.4
MISSOURI	110	28.6	44	2525	31.5	5.8
OKLAHOMA	102	28.3	26	3976	15.3	.1
CONNECTICUT	91	25.4	18	5027	14.2	-1.5
KENTUCKY	119	34.9	58	2062	26.4	5.4
ALABAMA	118	35.0	63	1891	24.1	6.8
IOWA	93	32.5	18	5212	33.5	8.6
SOUTH CAROLINA	103	36.9	48	2155	30.2	6.4
ARKANSAS	107	40.1	40	2669	25.0	8.8
MISSISSIPPI	83	31.8	54	1541	23.2	8.8
COLORADO	83	34.2	17	4851	25.6	-5.0
KANSAS	78	33.3	16	4872	19.9	3.9
RHODE ISLAND	72	36.0	29	2484	18.6	9.0
OREGON	57	30.3	16	3489	15.4	-.4
DIST. OF COLUMBIA	57	31.9	13	4305	12.4	1.1
MAINE	50	28.3	17	3025	18.7	.6
NEBRASKA	46	33.9	9	5048	14.2	.2
HAWAII	28	22.6	7	3784	29.5	4.9
WEST VIRGINIA	33	26.9	27	1183	22.5	4.3
UTAH	39	40.0	6	6391	21.0	.3
NEW MEXICO	40	41.4	16	2576	23.6	5.1
NEW HAMPSHIRE	18	20.7	5	3423	19.5	3.7
MONTANA	29	33.4	7	4131	19.0	2.0
VERMONT	31	39.5	6	4942	24.0	2.6
SOUTH DAKOTA	30	39.4	5	5574	34.4	5.1
NORTH DAKOTA	11	16.8	4	2738	12.6	4.7
NEVADA	28	42.1	4	6178	31.5	14.6
IDAHO	26	41.2	6	4590	17.6	2.6
DELAWARE	17	31.4	5	3745	29.6	6.6
ALASKA	20	39.3	4	5566	30.3	18.5
WYOMING	3	16.8	1	3140	16.8	-.5

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data were assembled by analysts at LaJolla Management Inc., and more extensive detail is available in Clinkscale et al. (1982). Attention will thereafter be focused on changes in state policies between 1980 and 1982, with an exploration of the linkages between state policy changes and the slowdown of expenditure growth in 1982.

4.1 Eligibility

A state's Medicaid program must cover all recipients of cash grants under the AFDC program, but states decide (a) whether or not to extend AFDC coverage to certain optional categories of individuals defined by the federal government, and (b) the income level and other criteria that a family must meet to become eligible for AFDC (and, thus, for Medicaid).

The monthly AFDC payment standard is the income cutoff determining eligibility for Medicaid. In 1982, for a family of 4 it ranged from a high of $634 ($7608 annually) in Alaska to a low of $148 per month ($1776 annually) in Alabama and Tennessee. These data are shown in the first column of Table 21. The monthly (annual) average for the 10 states with the highest payment standards was $542 ($6508), while those for the lowest 10 was $198 ($2376), a difference of $344 ($4130). Although some of the variation is undoubtedly attributable to differences in the cost of living, it is so large that those differences can be only a small part of the explanation.

Among the optional categories of eligibles are families with unemployed parents, unborn children, children age 18-21 who were regularly attending school, caretaker relatives, all financially eligible individuals under age 21, individuals eligible but not receiving aid, individuals eligible but in institutions, individuals who would be eligible if AFDC were as broad as the Act permits, and individuals who would be eligible if child care costs were paid from earnings. Only 4 jurisdictions covered 7 or 8 of these categories, while at the other end, 11 covered only 2 or fewer, as shown in the second column of Table 21.

For most of the states, people who are eligible for federal Supplemental Security Income (SSI) payments are also eligible for Medicaid, but 15 states in 1982 had a more restricted standard for Medicaid eligibility. They are called 209B states after the number of the section in the amendment to the law which permitted that practice. States with a more restricted standard must permit applicants to deduct from income costs incurred for the purchase of covered services whether or not they have a medically needy component to their program (to be described below).

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Table 21
Selected Eligibility Policies, 1982

	AFDC Payment Level Family of 4 ($/month)	Number of AFDC Optional Categ.	SSI Payment Level Aged Couple ($/month)
Average	362	4	453
ALABAMA	148	3	397
ALASKA	634	3	638
ARKANSAS	188	3	397
CALIFORNIA	601	4	815
COLORADO	379	6	674
CONNECTICUT	501	4	491
DELAWARE	312	4	397
DIST. OF COLUMBIA	349	8	427
FLORIDA	230	3	694
GEORGIA	227	1	397
HAWAII	546	6	421
IDAHO	345	4	444
ILLINOIS	368	2	467
INDIANA	327	0	397
IOWA	419	2	397
KANSAS	374	4	397
KENTUCKY	235	4	397
LOUISIANA	213	3	397
MAINE	378	4	412
MARYLAND	326	6	397
MASSACHUSETTS	445	6	611
MICHIGAN	470	4	433
MINNESOTA	520	5	441
MISSISSIPPI	252	2	397
MISSOURI	290	4	397
MONTANA	331	6	397
NEBRASKA	420	5	534
NEVADA	288	2	487
NEW HAMPSHIRE	392	2	413
NEW JERSEY	414	6	416
NEW MEXICO	281	3	397
NEW YORK	515	8	476
NORTH CAROLINA	210	2	397
NORTH DAKOTA	408	5	397
OHIO	327	6	397
OKLAHOMA	349	5	555
OREGON	409	6	407
PENNSYLVANIA	381	6	446
RHODE ISLAND	518	7	485
SOUTH CAROLINA	163	3	397
SOUTH DAKOTA	361	2	412
TENNESSEE	148	2	397
TEXAS	201	2	397
UTAH	438	5	417
VERMONT	558	6	453
VIRGINIA	305	4	397
WASHINGTON	501	6	433
WEST VIRGINIA	249	4	397
WISCONSIN	529	8	558
WYOMING	340	3	437

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In 1982, the federal payment for aged, blind, or disabled SSI eligibles (and thus the income-based eligibility cutoff) was $397 per month or $4764 per year. Twenty-nine states supplemented that amount, either because they were required to in order to maintain a previous grant level under the former federal/state Aid to the Aged, Blind, or Disabled program or at the discretion of the state for other reasons. The highest grants were California's $815 per month for the aged and disabled, and $958 per month for the blind. In most cases, the grant level was the same for all three categories, although a small number of states treated them differently. The final column of Table 21 reports the maximum payment for aged SSI recipients.

The states have additional options for coverage of SSI-related individuals. For example, they may decide to cover people receiving only a state supplement, individuals eligible for but not receiving SSI grants, and individuals who are eligible but living in institutions. Fourteen states covered at least 6 optional categories, and 11 states covered no more than 2.

States may choose to extend Medicaid coverage to individuals who meet the AFDC or SSI criteria defined above except that they have too much income to qualify for cash grants. These individuals would become eligible for "medically needy" coverage when their expenses are very large in relation to income and assets. In 1982, as shown in Table 22, 30 jurisdictions (including the District of Columbia) had a medically needy program. As with AFDC eligibility, states determined the net income level (up to 133 1/3% of the maximum AFDC payment to a family of the same size) for medically needy eligibility. Residents of a state with a medically needy program have better coverage than those in other states, because they have the opportunity to establish eligibility for at least a portion of large medical bills after paying a portion themselves.[14]

Another important element of medically needy coverage is the accounting period -- the number of months of income from which the incurred medical expenses are deducted. In general, a shorter period is

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[14]It was originally envisioned that the net income cutoff would be more than the AFDC income criterion; that is, when the AFDC level is subtracted from the medically needy level, the number (the medically needy band) should always be positive. In practice, however, for 5 states the medically needy band was zero, meaning eligibility was the same for both; and in 2 states, it was actually negative.

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Table 22
Coverage of the Medically Needy, 1982

	Medically Needy Program (1=yes)	Accounting Period (months)
ALABAMA	0	
ALASKA	0	
ARKANSAS	1	3
CALIFORNIA	1	3
COLORADO	0	
CONNECTICUT	1	6
DELAWARE	0	
DIST. OF COLUMBIA	1	6
FLORIDA	0	
GEORGIA	0	
HAWAII	1	6
IDAHO	0	
ILLINOIS	1	6
INDIANA	0	
IOWA	0	
KANSAS	1	6
KENTUCKY	1	3
LOUISIANA	1	3
MAINE	1	6
MARYLAND	1	6
MASSACHUSETTS	1	6
MICHIGAN	1	6
MINNESOTA	1	6
MISSISSIPPI	0	
MISSOURI	0	
MONTANA	1	3
NEBRASKA	1	6
NEVADA	0	
NEW HAMPSHIRE	1	6
NEW JERSEY	0	
NEW MEXICO	0	
NEW YORK	1	6
NORTH CAROLINA	1	6
NORTH DAKOTA	1	1
OHIO	0	
OKLAHOMA	1	4
OREGON	0	
PENNSYLVANIA	1	6
RHODE ISLAND	1	6
SOUTH CAROLINA	0	
SOUTH DAKOTA	0	
TENNESSEE	1	3
TEXAS	0	
UTAH	1	1
VERMONT	1	6
VIRGINIA	1	6
WASHINGTON	1	3
WEST VIRGINIA	1	6
WISCONSIN	1	6
WYOMING	0	

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advantageous for an applicant. Table 22 shows that 2 states used a one-month accounting period in 1982; 7, a 3-month period; and 20 of the remaining 21, a 6-month period.

4.2 Service Coverage

Title XIX requires that, to qualify for federal financial assistance, a state Medicaid program must cover certain mandated services (including inpatient and outpatient hospital services, physicians, skilled nursing facility services, laboratory and x-ray services, early and periodic screening, diagnostic and treatment services for children under 21, rural health clinic services, and family planning services and supplies) and may offer virtually any other service as an option. In addition, a state decides whether and how to limit the amount, duration, or scope of any covered service.

An informative matrix showing optional service coverage in all states in 1979 is published in the 1981 Medicare/Medicaid Databook (p.78). Only minor changes have occurred since then as noted in the subsection 4.5 below. In terms of expenditures, the most important optional service, by far, is that provided by Intermediate Care Facilities, which accounted in FY 1982 for nearly 30% of all Medicaid expenditures (see Table 4 above). Prescribed drugs and dental services are the two other most important optional services, accounting for 5% and 2% of total expenditures respectively. Measured by the proportion of recipients using each, prescribed drugs and dental care are even more important, as shown in Table 6.

States may place limits on the amount, duration, or scope of any covered service, and all but 2 states imposed at least some such restrictions. To illustrate, 42 states chose to place limits on coverage of inpatient hospital services such as the following: limits on the number of days per year, on pre-operative days and/or weekend admissions, on elective surgery or other specific procedures, on procedures that can be provided on an outpatient basis.

States with medically needy components to their Medicaid programs may cover fewer services or have more restricted coverage of the same services for those eligibles as for the categorical (i.e. AFDC or SSI recipients) eligibles. In most cases, the state has the same coverage for both groups, however. Only 6 of the 30 states that covered the medically needy in 1982 provided different coverage of the mandatory services for the 2 groups, and only 9 provided different coverage of the

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optional services.[15]

Some states required that for some services specific permission be received before they were provided. When a physician wants to furnish one among certain specified procedures, he must justify it to a state official and receive approval for its use in that specific instance. Payment is denied in cases in which approval has not been obtained. Only 8 states had no prior authorization requirements at all in 1982.

4.3 Payment of Providers

States also make decisions regarding reimbursement of providers. In general, they have had more flexibility in paying physicians and other practitioners than hospitals and other institutions because of detailed federal rules regarding payment of hospitals and nursing homes. Since each facility was to be paid on the basis of its own costs, principles were promulgated for the determination of allowable costs. In order to use other rules to pay institutions, a state had to apply for and obtain approval from the Secretary of the Department of Health and Human Services for that substitute arrangement. This has been changed by the OBRA legislation of 1981 as discussed in Section 1.2 above. Payment of physicians and other practitioners on the basis of charges need not be determined by each individual's own rates but on an administrative determination of the "reasonable charges" in the area.

Physicians are critical actors in the medical care process. Primary care physicians provide preventive services and are the first contact for care when illness strikes. Physicians control much of medical care expenditures by virtue of the referrals they make, the tests they order, the drugs they prescribe, and the hospitalizations they recommend. Therefore, it is important to examine physician reimbursement policy to determine the extent to which they receive Medicaid fees comparable to fees for private patients. Two elements require attention in this regard: the method of payment and the rate.

States have 4 principal options in determining the rules for setting the rates paid to physicians:

(1) Medicare principles: a physician's usual and customary charges with a maximum set at the actual charge or the 75th percentile charge in the area, whichever is lower.

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[15] In those states with different coverage, one of the consequences is that providers must know, not only whether the patient is eligible for Medicaid benefits, but also whether he qualifies under one of the welfare categories or as medically needy.

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(2) Medicare principles but with a maximum at less than the 75th percentile for the area.
(3) A fixed schedule of fees for covered services.
(4) A schedule of fees based on an established relative value study, which expresses the value of each service in units that permit comparisons of services. The basic unit charge is determined by other means.

Table 23 shows that in 1982, 25 states used Medicare principles, 13 with the maximum set at the 75th percentile and 12, at a lower level. Twenty-two states used a fixed-fee schedule, and only 2 (California and Nevada) used a relative value schedule. In the terms used above, Medicare principles permit a physician some ability to influence the fee he will receive since, even though they include a maximum, they are based on the physician's own charges. States with a fixed fee schedule set the rates, and participating physicians must accept them. Even if an updated relative value study is not used, relative fees are generally based on historical relative charges. It should be pointed out that under either system, a state may exercise additional control over the rates by delays in raising them to compensate for general inflation.

Data are available for the fee levels used in early 1982 for 3 common services (i.e. brief office visit, appendectomy, and obstetrical care). Since a high correlation was observed between the fees paid to generalists and specialists for each service, only those for generalists are presented in Table 23.

- Brief office visit: The range for this service was from a low of $4 in Massachusetts to highs of $23 in Alaska and $20 in the District of Columbia. The median was $10. Thirty-three states clustered between $9 and $14. Data for 4 states were missing.
- Appendectomy: Fees ranged from a low of $100 in Pennsylvania to a high of $513 in Nevada, with a median payment of $300. Six states were under $200, and 7 were over $400; 32 paid between $200 and $399. Data were not available for 5 states.
- Obstetrical care: The distribution was similar to that for the appendectomy, but at a somewhat higher level. The range was from a low of $100 in Pennsylvania to a high of $550 in Wisconsin, with a median of $354. Six states paid less than $250, and 10, more than $450, with 28 in the middle. Six states did not provide data.

For hospital inpatient service reimbursement, Medicare methods, until recent changes in the law, were based on a determination of a hospital's own costs, giving hospitals no incentive to excercise restraint in incurring costs. Observers have long considered this to be a major contributing cause of the inflation in hospital expenditures. Ten states had sought and obtained, prior to 1981, the Secretary's approval for a hospital reimbursement method other than Medicare

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Table 23
Physician Reimbursement Method and Selected Rates, 1982

		Average Physician Payment Rates		
	Method*	Brief Office Visit	Appendect.	Obstetrical Care
ALABAMA	2	12	405	450
ALASKA	1	23	366	479
ARKANSAS	2	9	300	475
CALIFORNIA	4	11	347	509
COLORADO	3	11	268	375
CONNECTICUT	3	7	240	290
DELAWARE	1	12	370	435
DIST. OF COLUMBIA	1	20		
FLORIDA	3	10	198	310
GEORGIA	2	12	330	340
HAWAII	1	14	400	326
IDAHO	3	11	365	450
ILLINOIS	3	11	250	375
INDIANA				
IOWA	1	12	280	377
KANSAS	1	7	268	332
KENTUCKY	2	12	256	360
LOUISIANA	1	12	438	396
MAINE	3	8	218	268
MARYLAND	3	9	177	260
MASSACHUSETTS	3	4	195	146
MICHIGAN	3	7	259	373
MINNESOTA	2	12	370	350
MISSISSIPPI	3	9	225	135
MISSOURI	3			
MONTANA	2	10	312	525
NEBRASKA	2			
NEVADA	4	13	513	539
NEW HAMPSHIRE	3	6	225	214
NEW JERSEY	3	7	184	210
NEW MEXICO	2	10	368	306
NEW YORK	3	7	160	200
NORTH CAROLINA	2	11	408	350
NORTH DAKOTA	1	10	398	
OHIO	2		225	
OKLAHOMA	1	11	448	453
OREGON	3	9	329	425
PENNSYLVANIA	3	11	100	100
RHODE ISLAND	3	12		300
SOUTH CAROLINA	2	7	298	306
SOUTH DAKOTA	3	10	345	325
TENNESSEE	1	9	399	384
TEXAS	3	11	368	382
UTAH	1	10	313	401
VERMONT	2	6	226	274
VIRGINIA	3	6	236	263
WASHINGTON	3	13	283	474
WEST VIRGINIA	3	10	230	255
WISCONSIN	1	14	449	550
WYOMING	1	11	358	358

*Coded as follows: 1=Medicare methods at 75th percentile, 2=lower percentile, 3=fee schedule, 4=relative value study

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principles. As of 1982, 33 states used Medicare methods, and as a result of the OBRA, 17 now had approval to use another method as shown in Table 24.

States have been permitted somewhat greater discretion in the methods of payment for long-term care facilities, especially for Intermediate Care. The payment methods can be distinguished by whether they employ a prospectively determined rate or a retrospectively determined rate, based on actual costs incurred. Table 23 shows that about half of all states established prospective facility-specific rates for long-term care facilities. There are two cases where states do not have the same approach to SNF and ICF rate setting. A smaller number (10) set rates retrospectively; and 6 used a combination of methods.

For skilled nursing facilities in FY 1981, 6 states paid a rate of $60 per day or more and 7 states paid $30 or less, as shown in Table 24. For intermediate care facilities, the range was $22 to $97, but the high rate was an outlier (Alaska), $39 more than the next highest rate. The median was only $8 above the minimum at $30. The rates paid to ICF/MR tended to be higher even than those for SNFs. The range was from $25 in Illinois to $167 in Alaska, which seems to indicate extreme differences in scope of service and patient characteristics across states for this type of facility. The next highest rate was paid in Massachusetts ($123). The median was $60. Data were missing for 10 states, including several of the largest (California, New York, and Pennsylvania).

4.4 Administration

The final area in which states make important decisions which may affect program outcomes is administration. Medicaid is a very complex program requiring policies in the three major areas already discussed and procedures for determining eligibility, paying bills, ensuring program integrity, and identifying trends and potential problems so that they can be avoided or limited. Most of these functions are performed by state employees, although in some instances, a state will contract with an outside firm. The principal examples of the latter are claims payment and the establishment and operation of the Medicaid Management Information System (MMIS). Administrative expenditures as a proportion of vendor payments varies considerably from a low of 2.4% in Massachusetts to 9.9% in Oregon, with a mean of 5.1%.

The wide variation across states in many areas of Medicaid policy constitute important "natural experiments" that warrant intensive study in conjunction with other data describing the health sector context in each state, so that effects of policy can be better understood.

Table 24
Selected Payment Policies and Rates, 1982

	Hospital Payment Method*	ICF Payment Method**	Average Daily Payment Rates ($) SNF	ICF	ICF/MR
Average			42	33	67
ALABAMA	0	1	31	24	94
ALASKA	1	2	97	97	167
ARKANSAS	1	3	26	25	65
CALIFORNIA	0	3	36	29	
COLORADO	0	1	29	28	56
CONNECTICUT	1	1	41	27	
DELAWARE	1	1	44	44	48
DIST. OF COLUMBIA	1	1	66	51	66
FLORIDA	1	1			
GEORGIA	0	1	29	26	84
HAWAII	1	2	72	58	84
IDAHO	0	1	33	30	73
ILLINOIS	0	4	33	23	25
INDIANA	1				
IOWA	1	1	36	24	65
KANSAS	1	1	28	22	34
KENTUCKY	0	1	43	28	71
LOUISIANA	1	3	32	27	56
MAINE	1	2	61	37	69
MARYLAND	0	2	36	36	115
MASSACHUSETTS	0	2	41	29	123
MICHIGAN	0	1	36	33	118
MINNESOTA	1	1	45	36	45
MISSISSIPPI	0	1	29	25	39
MISSOURI	0	1	37	30	72
MONTANA	1	1	37	37	57
NEBRASKA	1	1	38	23	55
NEVADA	1	4	40	39	77
NEW HAMPSHIRE	1	1		41	41
NEW JERSEY	0	1	46	39	66
NEW MEXICO	1	2	66	30	60
NEW YORK	0	1	68	43	
NORTH CAROLINA	0	4	41	30	84
NORTH DAKOTA	1	4	36	27	
OHIO	1	4	39	34	45
OKLAHOMA	1	3	29	28	60
OREGON	1	2	40	30	58
PENNSYLVANIA	1	2			
RHODE ISLAND	0	1	47	35	50
SOUTH CAROLINA	1	1	44	33	55
SOUTH DAKOTA	1	1	26	24	
TENNESSEE	1	1	41	27	
TEXAS	1	3	36	28	48
UTAH	1	4	39	34	48
VERMONT	1	2	48	36	82
VIRGINIA	1	1	51	38	50
WASHINGTON	1	2	34	34	34
WEST VIRGINIA	1	1	37	31	
WISCONSIN	0	1	42	32	61
WYOMING	1	1	34	34	

*Coded 1 if using Medicare reasonable cost rules.

**Coded as follows: 1=Prospective, facility-specific; 2=retrospective, facility specific; 3=prospective, class rates; 4=combination

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4.5 Changes in State Medicaid Policies and Expenditure Growth

The slowdown of expenditure growth from 1981 to 1982 appeared to coincide with changes in federal laws governing some aspects of Medicaid described earlier in Section 1.2. In the aggregate, both recipients and deflated payments per recipient declined. An important general question is how much of the declines can be attributed to specific state policy actions, to demographic changes, and to other determinants of expenditure. To answer this question is an ambitious undertaking and unfortunately the present constraints on data availability make a definitive response impossible at this time. Therefore, this report provides an exploratory review of policy changes and their possible effects on the expenditure slowdown.

Two analytical approaches are used. The first approach begins with an identification of states for which some important policy changes have been documented and proceeds to determine whether those states had a slower growth of payments after 1981 compared to the slowdown for all states. The second approach begins with the bivariate distributions of states according to expenditure growth before 1981 and after 1981 (tabulated in Section 3), picks out those states with large changes in their relative growth position, and searches for policy changes that might distinguish these states from others. One reason for including the second approach is to make use of a special catalog of program change information published by the National Governors Association (1982) that is not computer-readable but fills important gaps in other data sources. With either approach, one may not expect to determine statistically the independent effect of a particular policy change, but only whether "large" policy changes or "large" differences in expenditure growth have the expected qualitative associations across the states.

Some state Medicaid policies have been systematically assessed as of late 1980 and again in December, 1982, using conforming definitions for the two points in time.[16] The list of such policies is rather short, but includes the following important items: (a) whether states used Medicare reimbursement rules for inpatient hospital care, (b) AFDC income cutoff level (the "payment standard"), (c) AFDC coverage of two-adult families with unemployed parents, and (d) coverage of optional

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[16]The data for 1980 were assembled by Systemetrics Inc. under contract to HCFA, while the 1982 data are from LaJolla Management Inc. as described in Clinkscale et al. (1982).

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services for categorically eligible persons. For all but the last item, the predominance of policy changes were clearly in the direction of restricting expense.

Among the policies listed above, hospital reimbursement flexibility was most clearly affected by the federal OBRA legislation. In each of the other areas, states already had substantial discretion. Between 1980 and 1982, seven states implemented new methods of hospital inpatient reimbursement departing from Medicare "reasonable cost" rules. If those policies changes had the expected impact, one would have anticipated that these states would have had rates of hospital expenditure growth less than those of other states not adopting the change. In fact, no clear difference emerged. Of the seven states, three (Kentucky, Mississippi and Missouri) are shown in Figure 6 above to have changed, relative to all states, from a higher growth class during 1975-81 to a lower growth class in 1981-82. Three states (Alabama, Georgia and Wisconsin) made an opposite move, and the seventh state (Wyoming) remained in the class with the highest rates of growth in both periods. These outcomes fail to reveal a strong association between changes in method of hospital reimbursement and the 1982 slowdown of expenses. It is possible that the long run effects of these policies will be more substantial (see Morrissey, Sloan and Mitchell, 1983, for a discussion of short-run vs. longer-run effects of state rate-setting programs).

AFDC coverage of families with unemployed parents could be expected to be an important policy in a recession year such as 1982. Six states dropped this eligibility group between 1980 and 1982, while no states added it. The six states (Indiana, Iowa, Montana, Oregon, Utah and Washington) were undoubtedly able to restrict the number of recipients from what would otherwise have occurred. But because of the relatively small share of Medicaid expenses incurred by these recipients, the ultimate effect on total spending appears to be swamped by other factors. Only three of the states (Iowa, Oregon and Utah) were found to have an overall slowdown of expenditure growth relative to all states. This finding illustrates the general problem that a type of measurable policy change that was undoubtedly in the direction of restricting payments in 1982 may only weakly discriminate among the states as to explanation of differential growth rates.

The level of the AFDC "payment standard" automatically determines eligibility for Medicaid for this major class of recipients. Unlike the policy changes already discussed, which require specific actions to restrict program growth, the payment standard can be allowed to constrain growth over time by the "passive" approach of inaction or by

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raising the standard by a small amount in the context of general inflation. In fact, only 24 states raised the payment standard over the two year period, while three states (Pennsylvania, Michigan and Nevada) enacted reductions. Of the states raising the standard, New York and California enacted mid-sized increases of 8% and 7%. By contrast, the U.S. Bureau of Labor Statistics index of hourly wages grew 14% during this period. The following 5 states enacted increases of that much or more: Mississippi, Rhode Island, Alaska, Texas, and Georgia. Only 2 of these 5 states had above-average growth of payments for 1981-82. The overall association between the change in AFDC payment standard and relative growth of payments was not statistically significant.

The coverage of optional services for the categorically eligible does not seem to be a policy area used by states to reduce expenditure growth. No states eliminated coverage of Intermediate Care Facilities or Drugs. For all other optional services, only three states reduced their offerings, 2 showed no change, while 32 states added more than two covered services.[17]

The major gaps in the data used above concern eligibility for aged, disabled and medically needy persons, and limitations on coverage of the major expensive services in hospitals and nursing facilities. To review developments since 1980 in those areas, one may refer to the compendium of policy changes published by the National Governors Association (1982).

In regard to Medicaid eligibility for aged, disabled and medically needy persons in all categories, the NGA compendium distinguishes three types of changes: in the income criterion for eligibility, in definitions such as the personal needs allowances for people already in nursing homes, and lastly in rules such as the items to be included or subtracted from income to determine eligibility and payment levels. The compendium categorizes each change as positive, negative, or neutral with respect to the expected effect on Medicaid expenditures.

In the catalog of such changes for FY80 through FY82, 91 instances of policy change defined by NGA as tending to raise Medicaid expense and 50 instances of policy change tending to lower expense are found. The

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[17] Information about another important category, dental services, is uninterpretable at this time. Our data sources indicate a substantial increase in the number of states offering dental care, yet the volume of recipients and payments fell noticeably in 1982.

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"positive" changes are mostly to increase the income cutoff or the personal needs allowance, whereas the "negative" changes are mostly in the category of revising rules on inclusion or exclusion of family resources and expense items.

Looking across the states, the number of positive changes for a state varies inversely with the number of negative changes, yet the volume of negative changes appears to be more concentrated in a few states. California, Virginia, Hawaii, Massachussetts, Michigan and Tennessee had 3 or more negative policy changes; 21 states had 1 or 2 negative changes, while 23 states had no negative changes. Because the elderly and medically needy account for such large shares of Medicaid outlays, one expects to see expenditure effects of these changes in eligibility rules. Of the 27 states with a negative policy change in these areas, one-third reduced their growth of total Medicaid expense relative to all states. By contrast, of the remaining 23 only 2 (9%) reduced their relative growth. Restricting attention to nursing facility payments, 52% of the states with these negative eligibility changes reduced their relative expenditure growth. This area of policy change warrants further study to progress from qualitative tests of association to quantitative predictions of policy impact. For example, some of the apparently important changes reported by NGA deal with homestead exemptions, evaluation of assets transferred at below-market prices, treatment of life insurance as an asset, and definition of family financial responsibilities. From the experience of states changing these policies, it should eventually be possible to quantify the specific financial impacts on Medicaid payments.

To supplement this inquiry about eligibility policies, the number of SSI recipients by state, as published by the Social Security Administration, was examined. Overall, the number of SSI recipients declined by slightly more than 5% (nearly 300,000 persons). This decline was quite uniform across the states (standard deviation only 2%), and no significant association across states with expenditure growth change was found. This suggests that the tentative findings from the NGA data are not due to regulation of basic SSI eligibility, but to regulation of coverage of institutionalized and medically needy persons.

The NGA compendium was also used for a second type of exploratory test. In Figure 6, which shows changes in trends for hospital expense, two extreme groups of states can be extracted. Those states in the upper right cell went from relatively low to relatively high growth (G+ group), while states in the lower left cell went from relatively high to relatively low growth (G- group). The NGA catalog of changes in the limits on utilization or prices for hospital care can be searched to

determine whether the G- group implemented more restrictive changes (as defined by NGA) than did the G+ group.

The findings of this approach are that all 5 of the states in the G- group implemented substantive restrictive changes (e.g., reducing covered days from 21 to 14) while only 3 of the 7 states in the G+ group implemented such changes.

A similar approach was taken for nursing facility payments. The G+ and G- states can be found in the upper right and lower left cells of Figure 7. It was found that 3 of 5 states in G- implemented more restrictive limits and pricing formulae compared to none of the 6 states in the G+ group.

This exploration of some policy changes that may help explain the 1981-82 slowdown of growth in payments can be briefly summarized. Departures from Medicare rules for inpatient hospital payments or restriction of AFDC eligibility do not appear to have made a major contribution to the differences among states in the 1982 slowdown. On the other hand, it appears that restrictive changes in definitions of income and covered expense for SSI and medically needy groups, as well as utilization and price limits for hospitals and nursing facilities may have been important. The difficulty of explaining state-by-state variations in expenditure growth in relation to state policy characteristics has been noted by other authors. Recently, Dobson and Rodgers (1983), using data on individuals from the National Medical Care Utilization and Expenditure Survey, did not find convincing statistical evidence for effects of policy variables on Medicaid utilization.

5.0 CONCLUSIONS

This report has provided an overview of Medicaid payment trends, focusing attention on the slowdown in Medicaid payment growth from 1981 to 1982. A number of points concerning both the growth of Medicaid payments in the last decade and for 1981-82 are worth reviewing.

First, Medicaid payments over the past decade have been rising at a rate only slightly larger than the rate for medical care expenditures for the nation as a whole -- a rate of growth about 5 percent above the growth in the medical care price index.

The reasons for the growth in deflated Medicaid payments are varied, but one major factor was the rising use of new or previously little-utilized services. For example, since 1979, intermediate care

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facilities for the mentally retarded have accounted for 20 to 25 percent of total Medicaid payment growth each year.

Another major contributor to deflated Medicaid payment growth is the shift in recipient mix toward more expensive patients. This occurred despite an apparent lack of an aging in the Medicaid recipient population (the declining percentage of aged recipients is itself unexpected, given recent demographic trends). Rather, this shift to more expensive patients results from the growth of the disability population as a share of all Medicaid recipients and the shift from cash assistance recipients to the more costly medically needy and institutionalized recipients.[18]

A notable aspect of these trends is the absence of growth in the number of Medicaid recipients since 1975 (also a peak recession year) despite the sharp increase in the numbers of poor, from 26 million in 1975 to 34 million in 1982. Part of the reason for the increasing number of poor between these two recession years is the failure of personal income to keep up with the defined poverty level, which has risen sharply due to the high inflation rates during 1973-1980. Similarly, restraint exercised on upward adjustments in AFDC income eligibility levels might explain at least part of this decrease in the Medicaid recipient/poor population ratio (Table 3).

The slowdown in Medicaid payment growth in 1981-82 occurred for almost all service categories (Table 4) and for all four major eligibility categories (Table 7), with an absolute decline in payments for AFDC children. Most of this decline in payment growth appears to have resulted from the reduction in total number of recipients and the reduction in recipients using hospital inpatient and nursing facility services.

Thus, while the total number of recipients declined .8 percent from 1981 to 1982, the number of recipients using hospitals declined 3.7 percent and the number of recipients using nursing homes, not for the mentally retarded, declined 3.4 percent. While the number of disabled recipients declined 1.9 percent in 1981-82, ICF-MR recipients declined 11.2 percent, as compared to an annual growth rate in ICF-MR recipients of more than 20 percent between 1979 and 1981.

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[18]This may reflect an aging of the over-65 population from the "young-old" (ages 65-74) to the "old-old" (ages 75 and over) who are more likely to be institutionalized.

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The extent to which these recipient rates of growth have been reduced by intentional state policy is not entirely clear. We have noted the potential role of the 1981 Omnibus Reconciliation Act, which gave states a number of additional policy options and perhaps more importantly, increased the share of Medicaid payments the states would have to bear. Since the effect of unemployment in the recent recession may only show up in Medicaid eligibility with a time lag, fiscal 1983 data should be watched for a sharp increase in recipients. The lack of such an increase in numbers of Medicaid recipients for 1983 would certainly provide a strong indication of the potent effects of state limits on eligibility.

In general, it is difficult at this time to account for the differences in growth of payments (and the role therein of specific policies) among states, using the measured policy characteristics now available and ignoring the contextual factors affecting health care use and costs in each state. However, it appears from the exploration of Section 4.5 that important areas of restrictive policy change associated with differences between states in the reduction of payment growth for 1981-82 were utilization and price limits for hospital and nursing facilities, and rules for defining the patient's income assets and covered expense for medically needy as well as other persons in SSI categories. These exploratory findings and the quantitative effects of specific policies are subjects of ongoing study supported by HCFA.

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